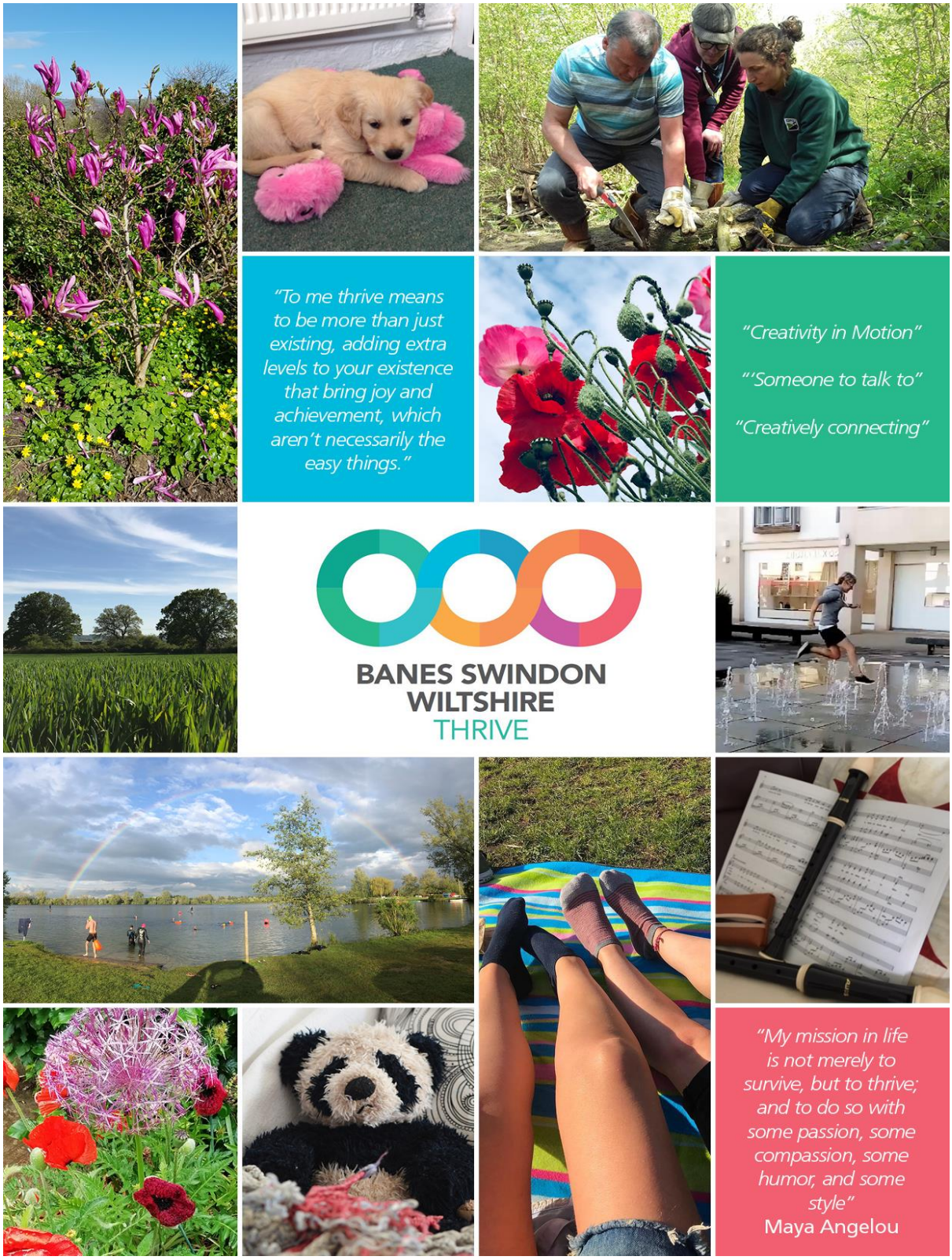

OUR VISION FOR MENTAL HEALTH AND WELLBEING

Foreword

By Caroline Mellers

Thrive is an exciting new opportunity for people living in BSW. In many ways I like to see it as a new beginning and a shift in how mental health is viewed and treated. This document highlights a shared commitment and enthusiasm to enhance the lives and wellbeing of people with mental health issues and an assurance that no one should be left in need.

I have been asked to write this foreword as a member of the BSW Thrive Board. I have had my own lived experience of mental health challenges as well as working with multiple agencies for nearly 5 years locally and regionally to raise awareness of mental health. My work has focused on co-creating a Charter in B&NES to protect the rights and expectations of people needing support for their mental health. I have also tried to encourage dialogue on mental health crisis, using my own lived experience as a foundation. The sole aim of my work is to help bring positive changes to the lives of people experiencing mental health challenges by working at a strategic level with people and organisations who can make a difference. This document is something I am very keen to see fully adopted within our community.

I would like to recognise the heartfelt commitment of many services and organisations (all too often overstretched by lack of resources and funding) to work more effectively to meet people's needs by involving people who have used services, and carers to co-produce and re-design services. Thrive is a golden opportunity for BSW organisations and the community at large to work together to share resources, best practice examples and to understand collectively how to improve people's mental wellbeing.

My own mental health journey has been very challenging and initially impacted on many areas of my life. I felt at the mercy of my symptoms and lost to myself and the world around me, with little self-worth and isolated from my community.

Mental health can affect so many areas of life such as drug and alcohol issues, homelessness, the ability to find and sustain work or find suitable accommodation. There are also key areas in BSW which needs to be addressed both in our community and nationally. One example is the number of young people self-harming or taking their own lives.

Looked at as a whole the impact of mental health can seem overwhelming;, but I often reflect on what I have heard so often from other people who have used services and also from their loved ones - it is often the simplest of gestures which can have the greatest impact.

I think it is difficult to quantify a simple gesture but at the heart of it is something that connects us all - a shared humanity. There is a rawness to mental health, and the impact chronic or acute human distress can have on individuals and their families is often underestimated.

It should be recognised that at the same time this can bring about misunderstanding, fear and stigma in individuals, their families, organisations and society at large. With Thrive it would be possible to focus on the strengths of people rather than limitations.

I recall a pivotal moment in my journey to wellbeing. A Doctor was able to connect with me and recognise the extent of my suffering. Working within his professional boundaries he was able to value me as a person who was struggling. He empathised with what I was experiencing and firstly spoke to me as person in distress, not as a diagnosis.

Well, here we have one of the many complexities in mental health. How can organisations support a person in distress, while following the required policies and procedures that the 'system' requires? My initial answer is that BSW Thrive have a stated intention to bring a more person-centred approach which truly puts the person at the heart of service delivery. In order for this to happen organisations need to clearly identify what a 'person-centred' approach means to them.

I feel the therapeutic and empathetic connection between people can greatly enhance wellbeing. It was the sincerity of the connection I felt with my Doctor that empowered me to take what control I could of my condition, rather than it controlling me. I began to value myself and learn what supported my mental wellbeing and wrote a wellbeing plan which I shared with my family and friends. The plan made my mental health diagnosis seem manageable and I have been in remission for 22 years (apart from one episode following a family bereavement 12 years ago).

In BSW there are increasing opportunities for people to learn more about managing their wellbeing, with peer mentors, support groups, easily accessible resources and talking therapies. With the introduction of Thrive and the integration of health and social support, I am hopeful that there will be consistency in provision of these services and opportunities to discover other areas where support may be needed to meet people's unique needs.

In my work I have heard many people talk of 'parity of esteem' and the fact that people with mental health needs should be valued equally to those with physical health needs. I embrace the national directive that people should have equal access to the most effective and safest care and treatment and that equal effort is put into improving the quality of their care.

I have seen a continued desire to understand the complexity of mental health by numerous health and social care organisations as they work towards parity of esteem. However, I also feel if parity of esteem fully existed in BSW, it would go a long way to reducing the self and societal stigma and discrimination associated with mental health. For many years I felt shame about my diagnosis, that I had done something wrong and was 'less than' the people around me. Treating physical and mental health equally would provide an holistic view of a person and any challenges they may face could be incorporated in their life as a whole and not a label that defines them.

I have mentioned complexity several times in this foreword. I guess it is so important to the lives and wellbeing of people that this complexity continues to be unravelled. I firmly believe a key to this is the continued development of genuine and collaborative and partnership working between organisations. I have been a part of numerous meetings with the NHS, Police and charitable organisations where there is a sincere desire to better understand the needs of people. However, I have to say I have witnessed a sense of 'us' and 'them' between some services. It is difficult to understand the root cause of this, but much of it is due to the impact of different systems in different services. Another factor could be the interface between statutory and 3rd sector services including competition for funding and resources. With Thrive there is an opportunity to greater understand how 'systemic' issues could be impacting on the adoption of person-centred care.

When I had a mental health crisis 12 years ago in New Zealand, I had a traumatic experience which was made considerably worse by services not working in partnership, ineffective information sharing and lack of communication. I would go as far as to say that services were bound by their systems, as opposed to being person-centred. By this I mean seeking how best to connect with me and, whilst recognising any risks, getting me the support I needed.

I feel that the support offered to people can often indirectly be hindered by these circumstances and it can prevent people from getting the most effective, timely and appropriate support to meet their needs. I would like to see the Thrive model being used for relationships in and between organisations which can impact, either directly or indirectly, on the experience of someone in distress.

I would like to finish by visualising what BSW would be like if people with mental health needs were supported in the right way, at the right time that meet their needs, both immediate and long term. These people would no longer be just surviving, but have opportunities to truly Thrive and grow and able to make their unique contributions to our community. Let's collectively ensure that the BSW Thrive Plan becomes a 'living' document with which everyone feels able to become involved to enhance the mental wellbeing of our community.

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1. Introduction

We are working together across BaNES, Swindon and Wiltshire (BSW) to transform how we deliver mental health support to better meet the needs of local people. There is a shared enthusiasm to enhance lives and wellbeing with a shared commitment that no-one should be left in need.

Regardless of personal circumstances, age or individual need, we will deliver the best mental health care and support. Local people should be confident that the challenges they face will be heard and that they will be offered appropriate help and support within their local communities with timely access to more specialist provision if required.

Our Thrive model, which is outlined in the background section, will drive forward improvements to mental health and wellbeing. We will deliver outcomes that are people-centric and based on the strengths of existing relationships with staff working together to support you and your family/ supporters. Collectively, we will offer solutions from diagnosis, early prevention and proactive support and provide effective and responsive pre-crisis and crisis care. This model, which is being co-produced with people with lived experience of mental health and mental wellbeing, will deliver effective interventions and treatments in the right place at the right time.

The vision also identifies areas that need more focus and areas of innovation to support a cultural change towards mental health literacy, recognition and capability across communities. You should feel respected, safe, and confident and be able to develop trusted relationships with skilled and compassionate staff. We also want people to be supported to lead a life they find fulfilling with opportunities to play an active role in planning their care with access to the support they need, when they need it.

2. Background

The BSW STP has co-produced our mental health strategy and vision with individuals and a range of organisations to meet the needs of local people both now and in the future. The journey to co-create our strategy commenced with developing an understanding of what issues we are trying to solve. Mental health problems can impact on all aspects of an individual such as:

- finding work and earning a good income
- being in a steady, long-term relationship
- living in decent housing
- being socially included in mainstream society
- live a long life (Having a severe mental illness can lead to people dying up to 20 years early due to preventable physical health conditions)
- leading a life that people find fulfilling

In 2017, the Mental Health Foundation commissioned a survey to understand the prevalence of self-reported mental health problems, levels of positive and negative mental health in the population. They found that:

- Nearly two-thirds of people (65%) say that they have experienced a mental health problem. This rises to 7 in every 10 women, young adults aged 18-34 and people living alone.

50% of mental health issues start before the age of 14; 75% start before 24 years old.

- Only a small minority of people (13%) were found to be living with high levels of positive mental health.
- People over the age of 55 report experiencing better mental health than average.
- More than 4 in 10 people say they have experienced depression
- Over a quarter of people say they have experienced panic attacks.
- The most notable differences are associated with household income and economic activity - nearly 3 in 4 people living in the lowest household income bracket report having experienced a mental health problem, compared to 6 in 10 of the highest household income bracket.
- The great majority (85%) of people out of work have experienced a mental health problem compared to two thirds of people in work and just over half of people who have retired.
- Nearly nine out of ten people with mental health problems say that stigma and discrimination have a negative effect on their lives.

The number of children and young people aged under 18 admitted to Emergency Departments with a primary diagnosis of a psychiatric condition has almost tripled since 2010/11.

In BSW STP:

- Mental Health service users are 2-4 times more likely to die of cancer, circulatory or respiratory disease than the rest of the population and at higher risk of other less common cause of death
- Excluding mental health disorders and disease of the nervous system, the highest relative rates of death in mental health service users compared to the STP population, are due to external causes such as injuries and burns, substance misuse, hypothermia and suicides

We have approached our challenge by co-designing our Thrive BSW programme and are already using the concept to drive forward our transformation. Thrive BSW is a long term complex and

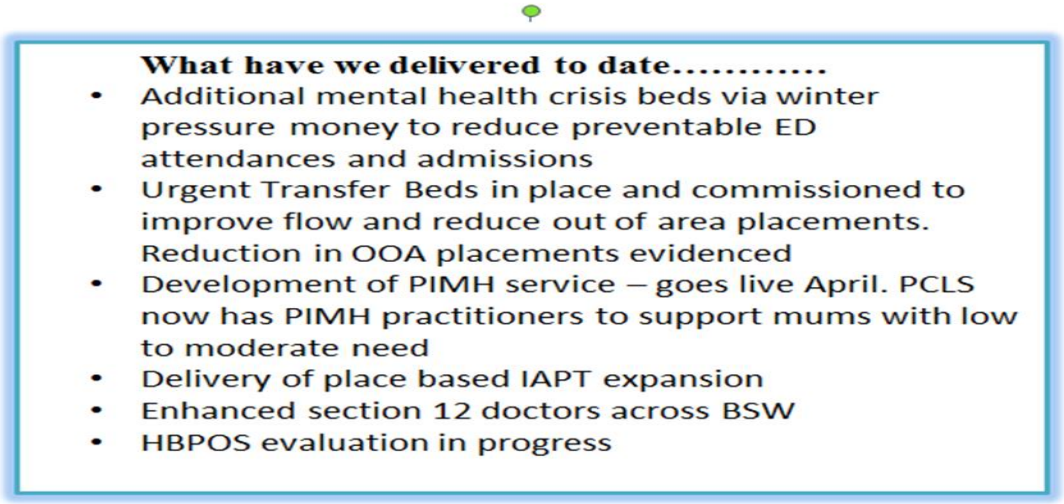
ambitious programme which brings all partners across public, private and voluntary sector together to improve mental health for local people. Thrive uses a public health approach to begin changing the way people think about mental health. The model offers a public health solution that includes all the following elements: prevention of illness, promotion of mental health and wellbeing, early detection of problems, and treatment.

Thrive has more recently been brought to the UK in West Midlands, London and Bristol through the global Thrive Cities network. Bath and North East Somerset (B&NES), Swindon and Wiltshire (BSW) Sustainability and Transformation Partnership (STP) are committed to develop Thrive BSW for their population.

Thrive BSW is a mental health and wellbeing programme for all ages to improve the mental health and wellbeing of everyone in the STP footprint, with a focus on those with the greatest needs. It covers all ages from prenatal to older people. It ranges from plans to improve the whole population's wellbeing to early interventions and specialist treatments for people experiencing mental illness.

Thrive BSW will bring together people, communities and public (NHS, Local Authorities, Police, Schools etc.), private and third sector organisations to work in collaboration for the benefit of the whole population's mental health and wellbeing. Thrive will also link with provider and neighbouring STP visions to ensure provision meets both place based needs as well as delivering at scale transformation opportunities where it makes sense for local people. Our vision for mental health transformation will support delivery of the mental health five year forward view and the deliverables of the NHS Long Term Plan to improve outcomes for people.

Our BSW Thrive approach links with the I-Thrive model, which is a national programme of innovation and improvement in child and adolescent mental health.



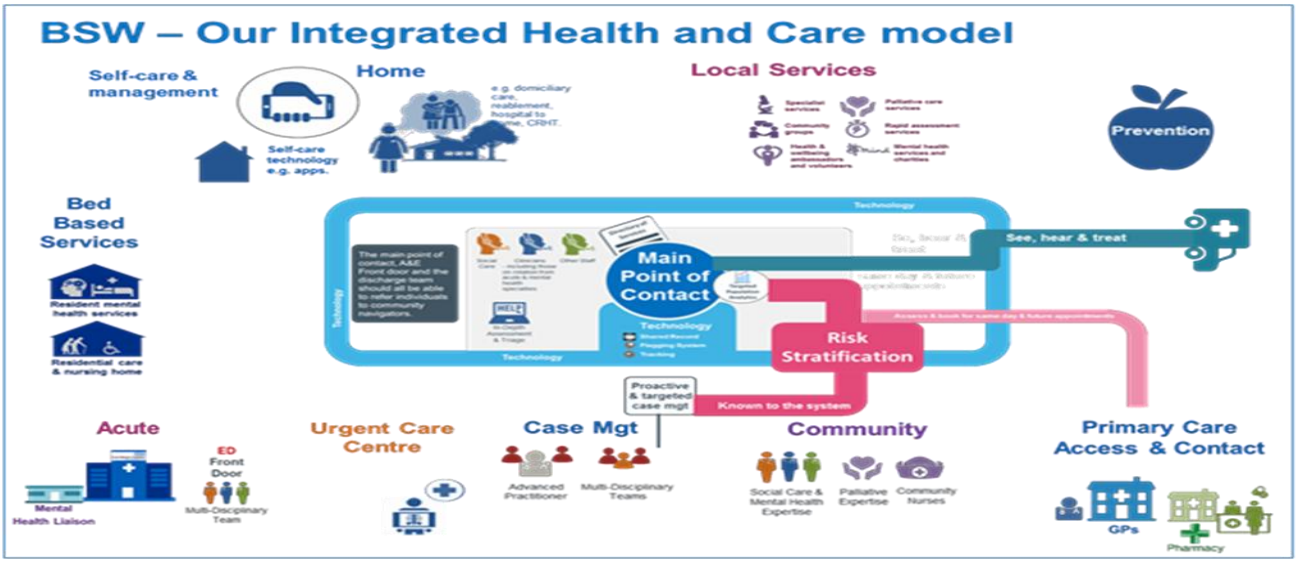
Our MH strategy sits under the umbrella of the BSW clinical strategy, which seeks to enable children and young people to 'Start Well', for people to 'Live Well' and older people to 'Age Well'. We want to develop a bold set of ambitions over the next 5 years for our combined population. Our priorities

are driven by a Health and Care Strategy (insert link when published) which clearly sets out our ambition for the people of BSW

to Start Well, Live Well, Age Well

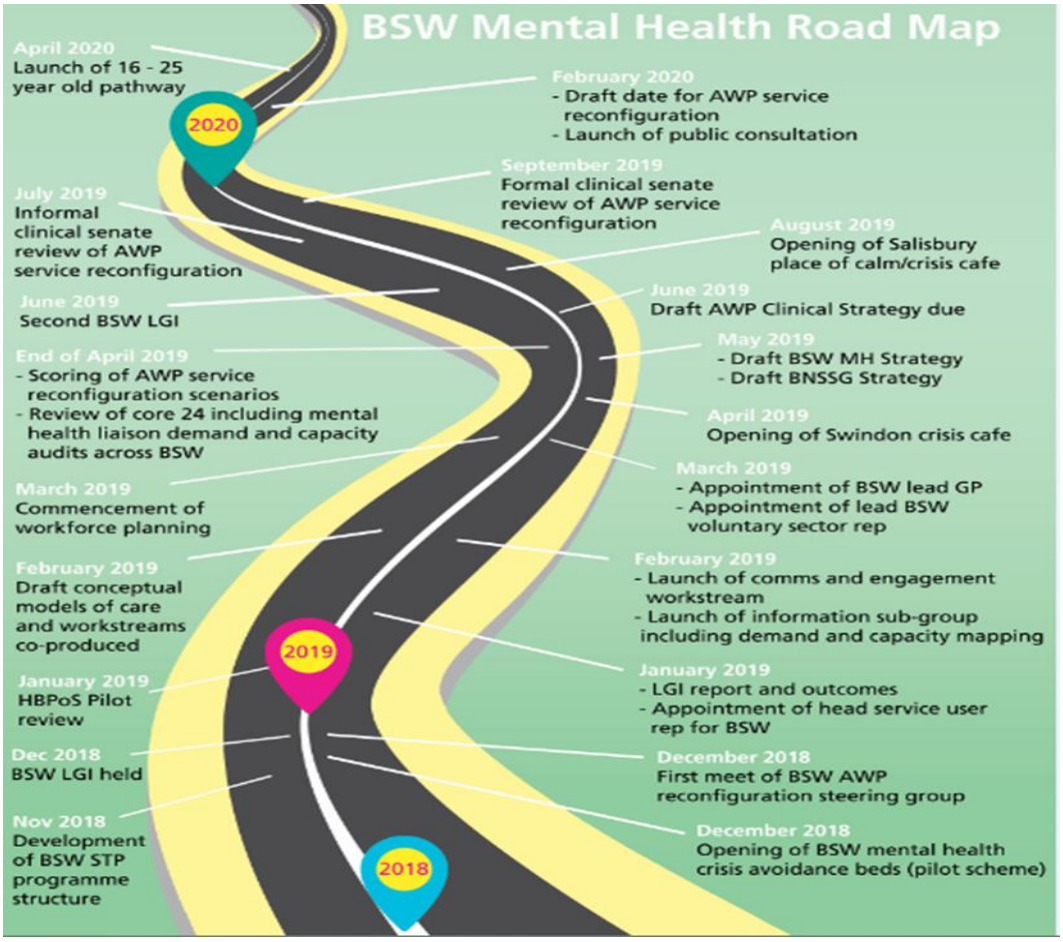
which we will help them do by

- Giving people more control over their own health, working with people, identifying their strengths and the resources within their communities and families to maintain their health and wellbeing
- Preventing illness and tackling ill health, promoting wellbeing, offering early help and support to people
- Tackling the big diseases that limit life and providing joined up care



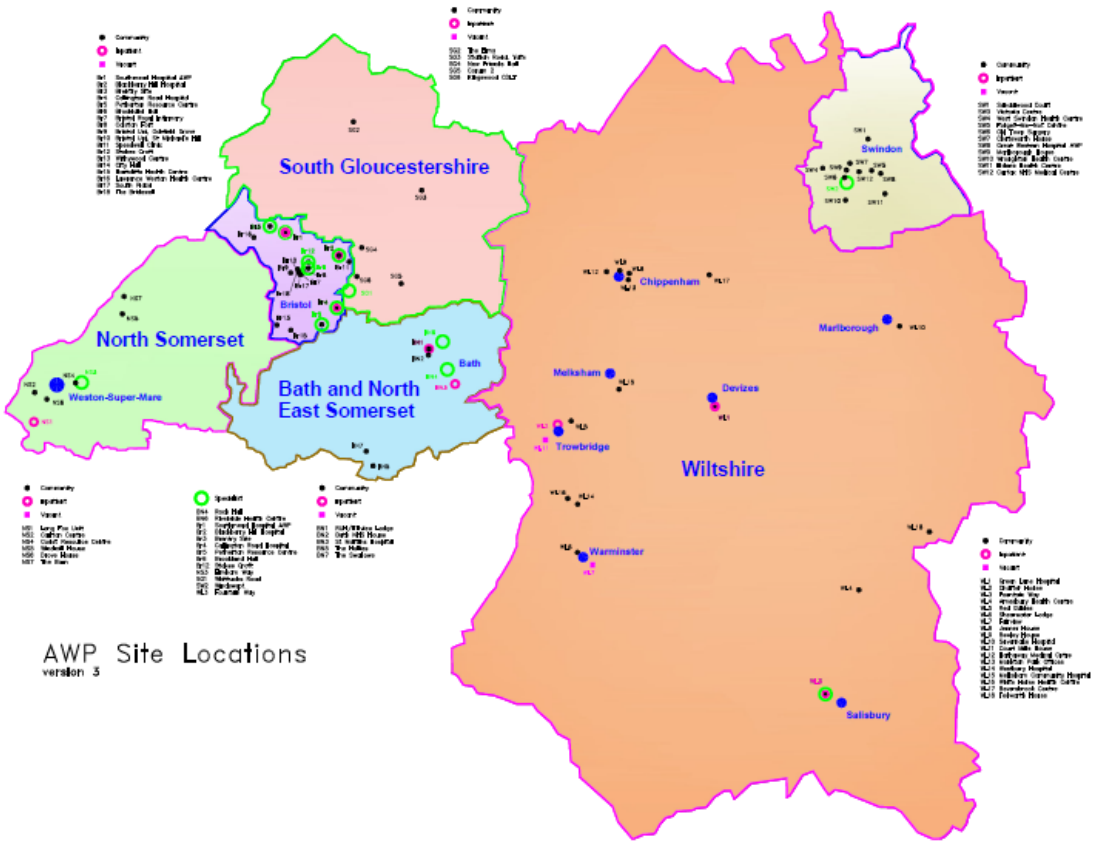
3. Transformation Roadmap

Our transformation journey is detailed in the roadmap below: The journey includes a total transformational review of mental health provision across BSW and a dedicated piece of service reconfiguration to review inpatient and community services provided by AWP across our footprint. This review is needed to address concerns involving unsustainable buildings and to ensure we co-design the right provision in the right location that better meets the modern day needs.



4. Our Local Mental Health System

NEED SOMETHING IN HERE TO DESCRIBE OUR CURRENT ADULT OFFER …… PLANNING TO HAVE TRIANGLE FROM CONCEPTUAL MODEL OF CARE AMENDED TO SHOW CURRENT PROVISION



Current CAMHS provision

In April 2018, a modern Child and Adolescent Mental Health service was commissioned across BSW. The service places a much bigger emphasis on early intervention and improved access. It reflects the THRIVE model in its design. The contract length is 7 +3 years, and the service will evolve and develop over that time. The key elements of this service include:

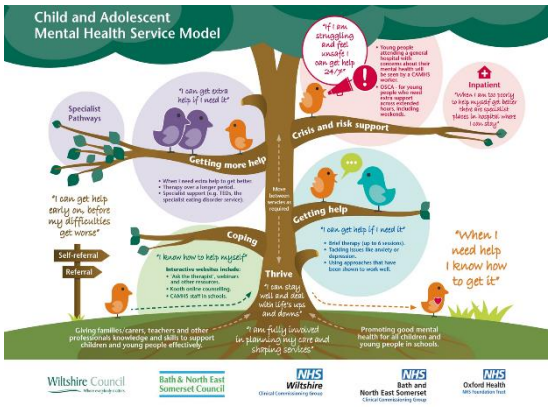
Self -referral

Children, young people and families can now refer to CAMHS without needing to visit a GP or make the request of an education professional.

So – children and young people have greater opportunities to be seen by reducing barriers to access.

A tierless model

Where children and young people can move seamlessly between support, interventions and therapy.



Access coordination

Every child and young person who does not meet the threshold for the current service offered by Oxford

Health CAMHS will be offered an 'access call'. This consultation enables the young person/referrer to describe the current situation and be referred to appropriate community-based services that can support their needs. There is also the option to refer back to CAMHS if symptoms change.

So – children and young people are given information and advice to support their lower-level needs at the right time

Services and support that children and young people/referrers might be referred or signposted to include:

- **CAMHS 'thrive' practitioners** based in 12 secondary schools and 3 Wiltshire College campuses (Chippenham, Lackham and Trowbridge). Practitioners offer direct 1:1 support, group work, consultation and training to staff, and parenting groups. Staff work in schools 1.5 days per week.

- Xenzone **Kooth** - online messaging and counselling, forums and articles.
  In Wiltshire, Kooth is available for children and young people 11-24 years (18-24 years being piloted in 2019/20 and targeted at care leavers/those who need a more flexible transition to adult support services).

- Relate '**Talk Zone**' counselling in five Wiltshire GP practices in areas of highest deprivation (Hathaway, Lodge, White Horse, Lovemead, Castle).

- Relate '**Time to Talk**' counselling in 27 primaries schools in in areas of highest deprivation.

- **www.onyourmind.org.uk** – a website designed for and by young people in Wiltshire which gives early help and advice, and which is developing continuously in response to feedback.

- **'harmLESS'** – a resource for adults who have contact with young people who are self-harming. The online resource is designed to help professionals talk about self-harm with a young person so they can decide what support might be helpful.

- **Peer mentoring** support – training commissioned from Kidscape and delivered in 'thrive' schools

- Volunteer **mentoring** delivered in targeted primary schools in areas of highest deprivation. 45 cyp accessed mentoring in 17/18.

- Allocated funding for services to support **perinatal mental health**, delivered by Avon Wiltshire Partnership. This new service offers primary care liaison and and brief interventions to support parent-child attachment. In addition, a successful Health Education England grant will fund specialist training for health visitors in 2019/20.

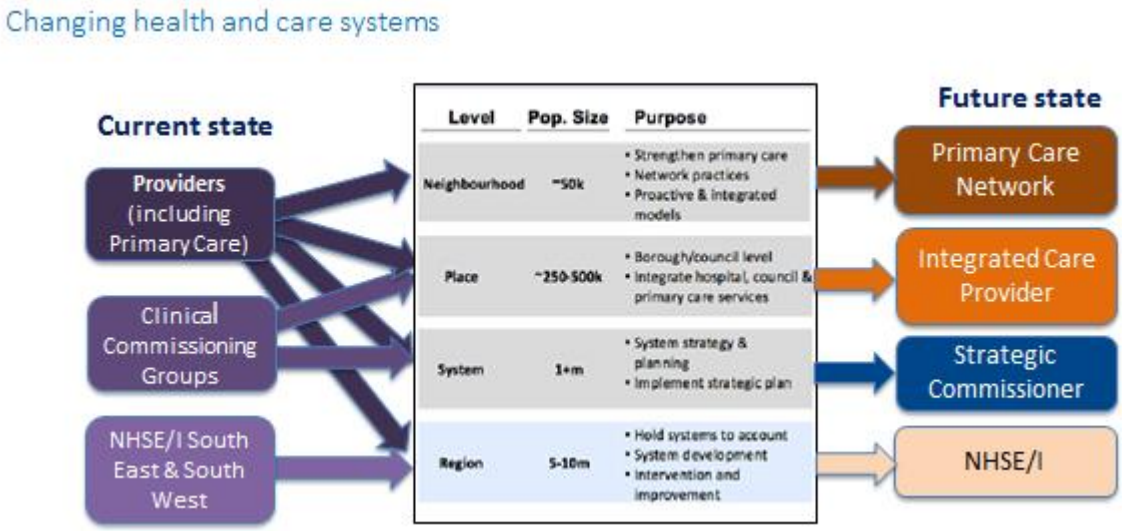
- The **SOMEHOW project** (Tidworth area) for case formulation around primary-age children with SEMH. This pilot project makes bets use of multi-agency working and digital innovation, with potenital to be rolled out, dependent upon evaluation.

- **Emotional Literacy Support Assistant** service/training (traded by Educational Psychology Team). New resources available to ELSAs from CAMHS transformation funds.
- Ministry of **Parenting STOP and PITT STOP programmes** – arranged for schools or community areas. 017 and July 2018 Attended by 139 parents in 17/18. 86% reported the group had made a difference to their teenager's behaviour, 84% reported the group had made a difference to their relationship with their teenager. 96% felt that the group had met their expectations and 100% felt supported/very supported by the group facilitators.
- Delivery of **Youth Mental Health First Aid** training for school clusters, local authority and agency staff, offered at subsidised rates to increase accessibility. Delivered to 154 staff in 2017/18 across primary and secondary schools.
- Wiltshire **Healthy Schools programme** - available to support schools to implement a whole school approach to emotional wellbeing and mental health. The Wiltshire Healthy Schools website has been used to enable schools to access a range of information and support on emotional wellbeing and mental health. Alongside this is a programme of training including **Time to Change** - enabling secondary school staff to access hard copies and online educational resources to engage young people to address stigma around mental health.

Developed an all age **sexual assault referral pathway** across Swindon and Wiltshire with funding from the Health and Justice Commissioner. The funding offers a pyschological perspective to sexual assault trauma using Eye Movement Desensitization and Reprocessing (EMDR) therapy.

4.1 Governance

The health landscape is changing as detailed in the diagram below. This hasn't stopped our mental health transformation journey.

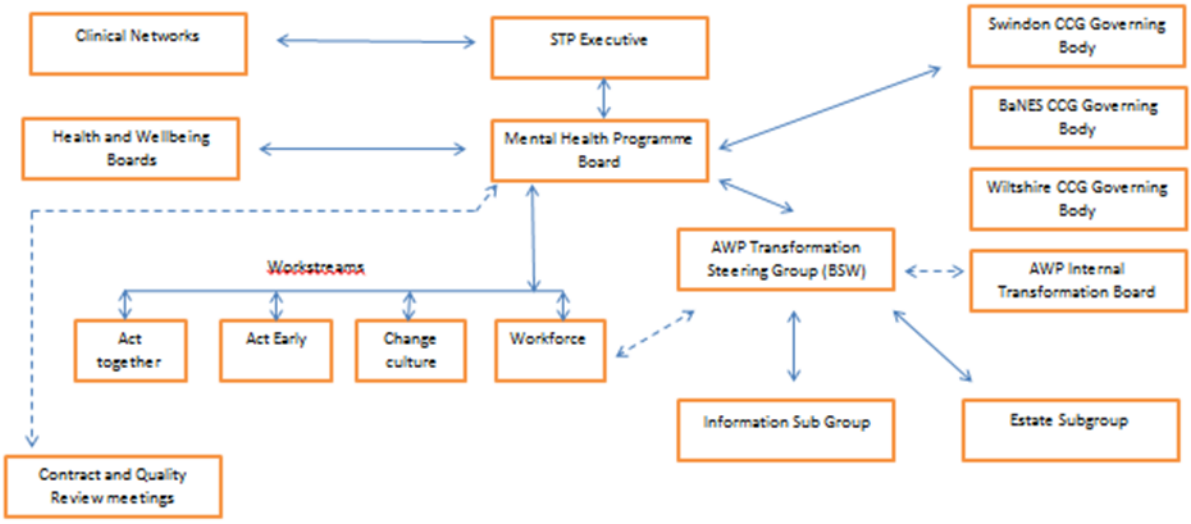


We have developed closer links with Bristol, North Somerset and South Gloucestershire CCG to co-create and commission appropriate services across a wider geography, where it makes sense for our local population, to support people's pathways and provider sustainability. This also means that our work recognises that the AWP geographical footprint is wider than the BSW area, which will help in planning around more specialist services such as psychiatric intensive care and mother and baby unit provision.

A single Thrive BSW Mental Health Transformation Programme Board is in place that highlights the commitment to meet the needs of people in the BSW community by working collaboratively on the following:

1. Vision for mental health services for BSW including LD and ASD
2. Covers all ages
3. Delivery of Five Year Forward View (5YFV) and requirements of the Long Term Plan
4. Parity of Esteem
5. Mental Health Investment Standard
6. Provider transformational programme
7. STP transformation programme
8. New care models

Our governance framework is detailed in the diagram below:



4.2 **Mental Health Contract Management**

Contract management of mental health providers is now undertaken at scale across BSW for our main providers of adult and children and young people mental health. This includes engagement with place based partners such as local authorities. BSW works closely with BNSSG as part of the AWP contract arrangements at scale.

A multi-agency workshop will be held by the end of July 2019 with AWP to co-create a revised approach to contract management and reporting to support transformation activities and the new BSW at scale approach.

4.3 How do we compare to others ?

What does Right care tell us ?

Awaiting right care pack

5 Our local population

BSW has worked together to understand the needs of our local population. This includes identifying local needs at neighbourhood and place based footprints to provide targeted and tailored support for each demographic area. Our vision will address population specific needs in parallel with designing and delivering support when people need more specialist care and input at a larger scale. Our work has included a focus on incorporating issues related to inequality and diversity.

B&NES, Swindon and Wiltshire span a large geographical area of 3,875 km2 with a total population of 905,084 based on ONS 2017 mid-year estimates. Each area has distinctively different geographies and demographics which are important to consider when transforming mental health services.

Wiltshire is a predominantly rural area covering an area of 3,255 km^2.and population density averages 152 people per km^2. It is largely white-British population with less people from ethnic minorities than the national average. The Wiltshire population structure has a higher proportion of older people than the national average and projections suggest that in 2026 the number of people over 65 will exceed the number under 20.

Military rebasing is a significant driver of population growth in Wiltshire; by 2020 it is expected there will be ~18,000 serving military personnel many of whom will have spouses and children.

Swindon borough consists of the large town of Swindon and its surrounds. It covers an area of 230 km^2 and the average population density is 958 people per km^2. The 2011 Census showed population growth to be faster in Swindon than the England average and the population from minority ethnic groups nearly doubled in ten years.

B&NES consists of the city of Bath and the surrounding rural areas and towns of North East Somerset. There are about 189,000 residents in the area, half in Bath and half across the wider district. About 10% of the population are non-white-British. The local population's age structure is similar to the UK's population as a whole, however there is a higher number of people aged between 20-24 years due to a large student population from two universities. Between 2001 and 2017, the growth in the 20-24 age range accounted for nearly 50% of the area's population growth. B&NES is less deprived than national averages although there are still significant inequalities within the district, such as a life expectancy for males in the most deprived areas that is 8 years shorter than for males in less deprived neighbourhoods.

Deprivation

Health inequalities are variations in health between population groups resulting from a variety of societal and economic processes that are unequally distributed within or between populations. They are avoidable and unfair.

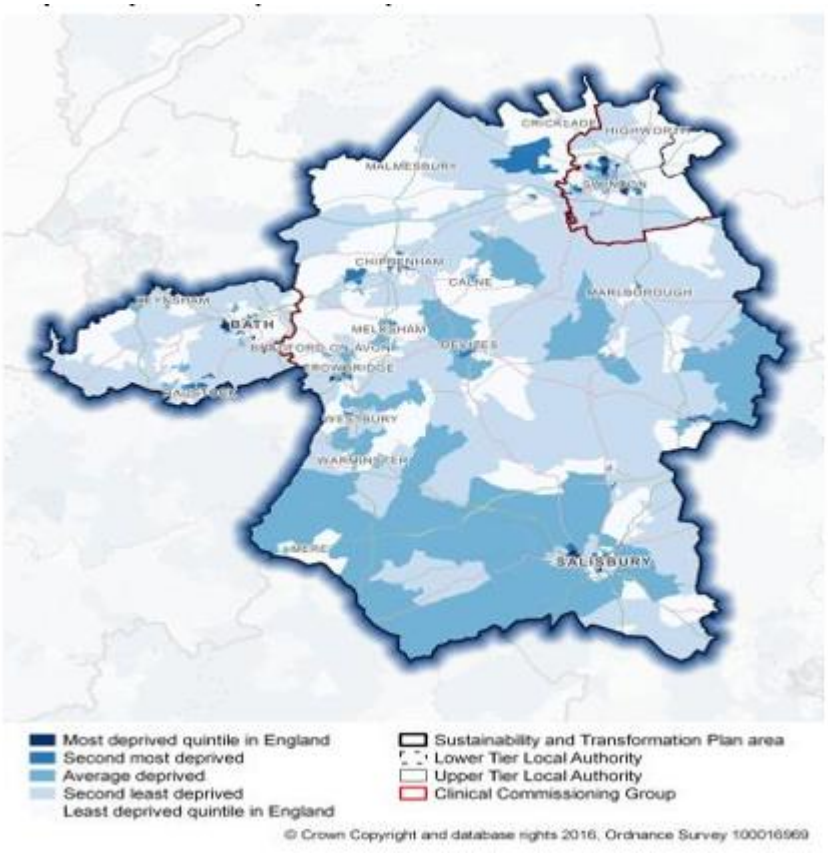
Health inequalities can occur at a number of levels including exposure to risk factors, health services provision and utilisation, health outcomes and life expectancy. They are often

strongly associated with levels of deprivation with those with the least in terms of socio economic status suffering the most in terms of poor health.

Mental health and deprivation are closely linked. Deprivation is thought to have an impact as both a cause and a consequence of poor mental health.

The Index of Multiple Deprivation (IMD) ranks the 32,844 Lower Super Output Areas (LSOAs) in England in terms of deprivation. LSOAs contain about 1,500 people. Wiltshire and B&NES are considered to be generally prosperous areas; however, there are hidden pockets of deprivation as illustrated in Map 1. Based on 2015 IMD data, 12 LSOAs in Wiltshire are within the 20% most deprived LSOAs in England and five in B&NES. Deprivation is more evident in Swindon with 19 LSOAs within the 20% most deprived nationally and eight of those are in the 10% most deprived.

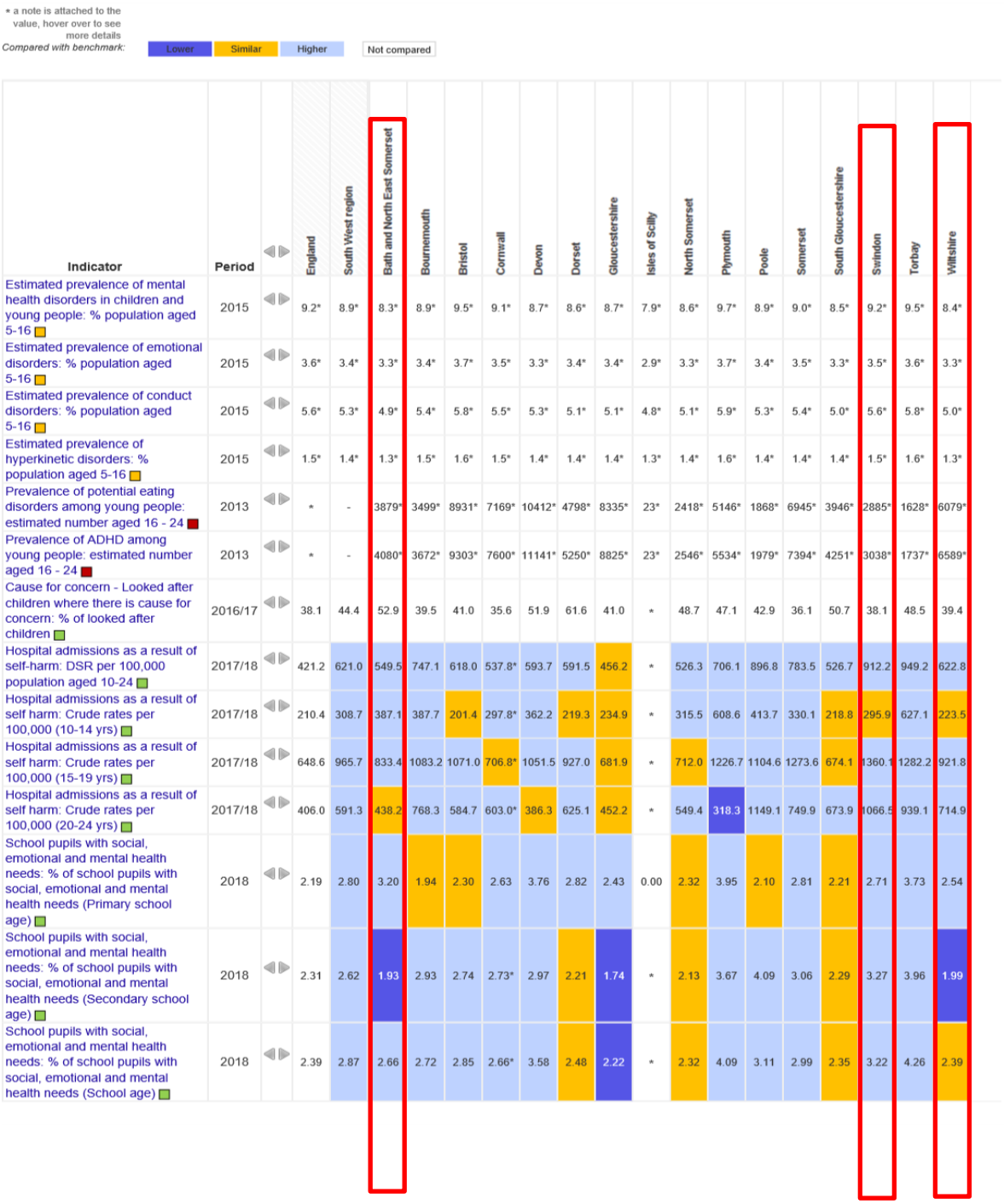
Map 1: Deprivation quintile map 2016



Prevalence of Mental Health Problems

There is limited comparable prevalence data for mental disorders, particularly in children and young people. The data below from the Public health England fingertips tool provides

information on a range of prevalence measure for mental health in children and young people and illustrates outcomes in B&NES, Swindon and Wiltshire across a range of these and compares them to National figures.



* a note is attached to the value, hover over to see more details

Compared with benchmark: Lower | Similar | Higher | Not compared

Indicator	Period	England	South West region	Bath and North East Somerset	Bournemouth	Bristol	Cornwall	Devon	Dorset	Gloucestershire	Isles of Scilly	North Somerset	Plymouth	Poole	Somerset	South Gloucestershire	Swindon	Torbay	Wiltshire
Estimated prevalence of mental health disorders in children and young people: % population aged 5-16	2015	9.2*	8.9*	8.3*	8.9*	9.5*	9.1*	8.7*	8.6*	8.7*	7.9*	8.6*	9.7*	8.9*	9.0*	8.5*	9.2*	9.5*	8.4*
Estimated prevalence of emotional disorders: % population aged 5-16	2015	3.6*	3.4*	3.3*	3.4*	3.7*	3.5*	3.3*	3.4*	3.4*	2.9*	3.3*	3.7*	3.4*	3.5*	3.3*	3.5*	3.6*	3.3*
Estimated prevalence of conduct disorders: % population aged 5-16	2015	5.6*	5.3*	4.9*	5.4*	5.8*	5.5*	5.3*	5.1*	5.1*	4.8*	5.1*	5.9*	5.3*	5.4*	5.0*	5.6*	5.8*	5.0*
Estimated prevalence of hyperkinetic disorders: % population aged 5-16	2015	1.5*	1.4*	1.3*	1.5*	1.6*	1.5*	1.4*	1.4*	1.4*	1.3*	1.4*	1.6*	1.4*	1.4*	1.4*	1.5*	1.6*	1.3*
Prevalence of potential eating disorders among young people: estimated number aged 16 - 24	2013	*	-	3879*	3499*	8931*	7169*	10412*	4798*	8335*	23*	2418*	5146*	1868*	6945*	3946*	2885*	1628*	6079*
Prevalence of ADHD among young people: estimated number aged 16 - 24	2013	*	-	4080*	3672*	9303*	7600*	11141*	5250*	8825*	23*	2546*	5534*	1979*	7394*	4251*	3038*	1737*	6589*
Cause for concern - Looked after children where there is cause for concern: % of looked after children	2016/17	38.1	44.4	52.9	39.5	41.0	35.6	51.9	61.6	41.0	*	48.7	47.1	42.9	36.1	50.7	38.1	48.5	39.4
Hospital admissions as a result of self-harm: DSR per 100,000 population aged 10-24	2017/18	421.2	621.0	549.5	747.1	618.0	537.8*	593.7	591.5	456.2	*	526.3	706.1	896.8	783.5	526.7	912.2	949.2	622.8
Hospital admissions as a result of self harm: Crude rates per 100,000 (10-14 yrs)	2017/18	210.4	308.7	387.1	387.7	201.4	297.8*	362.2	219.3	234.9	*	315.5	608.6	413.7	330.1	218.8	295.9	627.1	223.5
Hospital admissions as a result of self harm: Crude rates per 100,000 (15-19 yrs)	2017/18	648.6	965.7	833.4	1083.2	1071.0	706.8*	1051.5	927.0	681.9	*	712.0	1226.7	1104.6	1273.6	674.1	1360.1	1282.2	921.8
Hospital admissions as a result of self harm: Crude rates per 100,000 (20-24 yrs)	2017/18	406.0	591.3	438.2	768.3	584.7	603.0*	386.3	625.1	452.2	*	549.4	318.3	1149.1	749.9	673.9	1066.5	939.1	714.9
School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs (Primary school age)	2018	2.19	2.80	3.20	1.94	2.30	2.63	3.76	2.82	2.43	0.00	2.32	3.95	2.10	2.81	2.21	2.71	3.73	2.54
School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs (Secondary school age)	2018	2.31	2.62	1.93	2.93	2.74	2.73*	2.97	2.21	1.74	*	2.13	3.67	4.09	3.06	2.29	3.27	3.96	1.99
School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs (School age)	2018	2.39	2.87	2.66	2.72	2.85	2.66*	3.58	2.48	2.22	*	2.32	4.09	3.11	2.99	2.35	3.22	4.26	2.39

Common Mental Disorder

There are an estimated 26,000 people in B&NES, 29,000 in Swindon and 67,000 people in Wiltshire experiencing a common mental disorder (CMD) such as anxiety or depression. These mirror the different population sizes of each area. The percentage of people with

depression or other common mental disorders is very similar in each of the three areas, although Swindon is generally has a slightly higher prevalence than B&NES and Wiltshire. These percentages are shown in the table below.

Indicator	Period	England	South West (North) NHS region	NHS Bath And North East Somerset...	NHS Bristol, North Somerset and S...	NHS Gloucestershire CCG	NHS Swindon CCG	NHS Wiltshire CCG
Depression: Recorded prevalence (aged 18+)	2017/18	9.9	9.9	9.0	10.8	9.4	10.1	9.1
Depression: QOF incidence (18+) - new diagnosis	2017/18	1.6	1.6	1.7	1.9	1.5	1.5	1.3
Estimated prevalence of common mental disorders: % of population aged 16 & over New data	2017	16.9*	-	14.1*	16.2*	14.6*	15.2*	13.6*
Estimated prevalence of common mental disorders: % of population aged 65 & over New data	2017	10.2*	-	8.6*	9.8*	9.1*	9.4*	8.8*
Long-term mental health problems (GP Patient Survey): % of respondents (aged 18+) New data	2017/18	9.1	8.6*	9.0	10.5	8.8	8.8	7.9
Depression and anxiety prevalence (GP Patient Survey): % of respondents aged 18+	2016/17	13.7	12.7*	12.1	-	12.2	13.7	11.1

Source: https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders

The prevalence rates for CMDs are growing faster in women than men. Treatment seeking habits are changing with 37% of cases now seeking and receiving treatment compared to 23% seven years ago. This increase in treatment is seen across the number of prescriptions, GP consultations, community care appointments and IAPT sessions.

Applying the 37% treatment rate to B&NES, Swindon and Wiltshire, we would expect around 45,000 people to be receiving treatment for a CMD. Prevalence of severe mental illness for people living in B&NES also appears to be very similar to national averages.

The definition of CMD features in the following: https://fingertips.phe.org.uk/profile/common-mental-disorders/data#page/6/gid/1938132720/pat/46/par/E39000043/ati/154/are/E38000206/iid/90853/age/240/sex/

Post-Traumatic Stress Disorder

Within Banes, Swindon and Wiltshire, based on national prevalence rates, we can expect around 27,000 people to be experiencing PTSD. Adjusting for the military and veteran population this number may be even higher.

This population is believed to be largely undiagnosed currently. Many of those with PTSD have other co-existing mental health issues making them complex cases requiring more specialist treatment.

Eating Disorders

There are an estimated 11,000 people in Banes, Swindon and Wiltshire with eating disorders of whom the majority are younger women. Prevalence rates are thought to be growing. It is estimated 8/10 people nationally with eating disorders currently receive no treatment representing a large, under-served population.

Psychotic Disorders

Nationally the rates of psychotic disorders are thought to be stable at around 0.5%, translating to an estimated 3,800 cases in Banes, Swindon and Wiltshire. National incidence rates suggest we would expect to see 44 new cases in Banes, Swindon and Wiltshire per year.

Personality Disorders

There are an estimated 40,000 people in Banes, Swindon and Wiltshire with a personality disorder. According to national data around two thirds will not be receiving treatment although around 10-15% will have requested treatment. Again, this represents an underserved population.

Bipolar Disorder

There are an estimated 14,000 people in Banes, Swindon and Wiltshire living with bipolar disorder. This is a lifelong condition that can have significant impact on a person.

Self-harm

The reported prevalence of self-harm is rising particularly amongst young women; a quarter of 16-24 year old women report self-harming. Overall, there are estimated to be around 53,000 cases of self-harm in Banes, Swindon and Wiltshire a year. Most go unreported but there were around 2,400 emergency inpatient hospital admissions for self-harm in 2017/18 and admission rates are significantly higher in all three local areas than England overall.

Suicide

The suicide rate has fallen very slightly across BSW in the last few years, with rates being similar in each of the three areas.

Drug and Alcohol misuse

It is estimated that 24.2% of people aged between 16 and 74 years in B&NES are hazardous or problem drinkers. This suggests that more than 39,976 people are drinking at a level that is causing them actual or potential harm.

Furthermore, there are about 6,854 people aged 18-64 years in B&NES that are dependent on alcohol.

There are around 1000 opiate and crack cocaine users in B&NES,

Around half of all new substance misuse clients in B&NES present with a mental health need. A proportion of these clients (slightly less than one third) appear to have difficult accessing appropriate mental health support.

There are an estimated 12,200 harmful drinkers in Wiltshire. The prevalence is growing in 55-64 year olds and falling in 16-24 year olds. This is a change and one services will need to adapt to.

There are an estimated 12,100 people with a drug dependence in Wiltshire (includes cannabis, legal highs, opioids etc).

In Swindon, an estimated 20.5% of adults drink more than the recommended 14 units of alcohol per week. This equates to around 35,000 adults. In 2016/17, there were an estimated 1,075 opiate and crack users in Swindon.

Homelessness

The latest figure for B&NES estimates that there were 20 people sleeping rough on the night between 1st October and 30th November 2018 - 13 (65%) males and 7 (35%) females; with the vast majority, 18 (90%), aged 26 and over. The rate per 10,000 households of rough sleepers is higher in B&NES compared to national - 2.6 and 2.0 respectively in 2018. The number of people sleeping rough in B&NES will inevitably fluctuate throughout the year.

Risk Factors for Poor Mental Health

There are a number of risk factors for experiencing poor mental health. The relationship between risk factors and mental health is often complex with many factors being both causes and effects of poor mental health.

Factors affecting mental health can be divided into social, place-based determinants and behavioural factors (PHE, 2017b). Place-based determinants of mental health include;

- Deprivation & inequality
- Financial insecurity
- Housing & homelessness
- Education & lifelong learning
- Employment
- Crime, safety & violence.

Behavioural factors include smoking, physical activity and substance misuse. There is a two-way relationship between health behaviours and mental health, with each affecting the other. The prevalence of smoking and obesity is higher among those with mental health conditions. Negative health behaviours, whether a cause or consequence of mental health conditions, contribute to physical health inequalities in this population.

Social factors underpin health behaviours and mental health. The prevalence of common mental health problems is double and the prevalence of psychotic disorders is 9 times higher in the lowest quintile of household income compared to the highest (PHE, 2017b). Smoking and obesity are also associated with deprivation.

Adverse childhood experiences are also a risk factor for poor adult mental health and increased risk of self-harm and suicide.

An understanding of local risk factors and their distribution allows services to be tailored to effectively manage local need. Risk factors can occur at a number of levels and this means that there are certain groups at increased risk of poor mental health as well as broader societal factors that can put people at risk. Full details of protective and risk factors can be found within the detailed Health Needs assessment attached as appendix xxx.

At risk populations may share some common characteristics but are diverse groups with diverse needs that need to be addressed at the individual level if services are to be effective. As a result, services need to be culturally competent to cope with diverse groups.

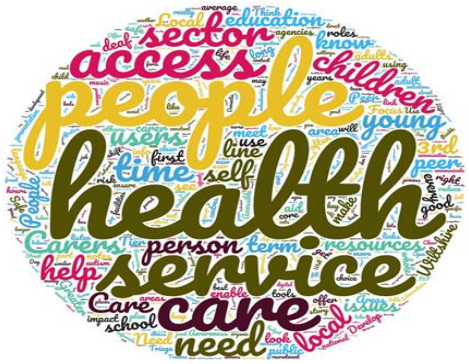
Within BSW STP key high risk groups include minority populations , older people, carers, military personnel, dependents and veterans, those with other issues such as poor physical health or learning disabilities and those at transition points in their lives e.g. moving out of care.

Our Engagement work

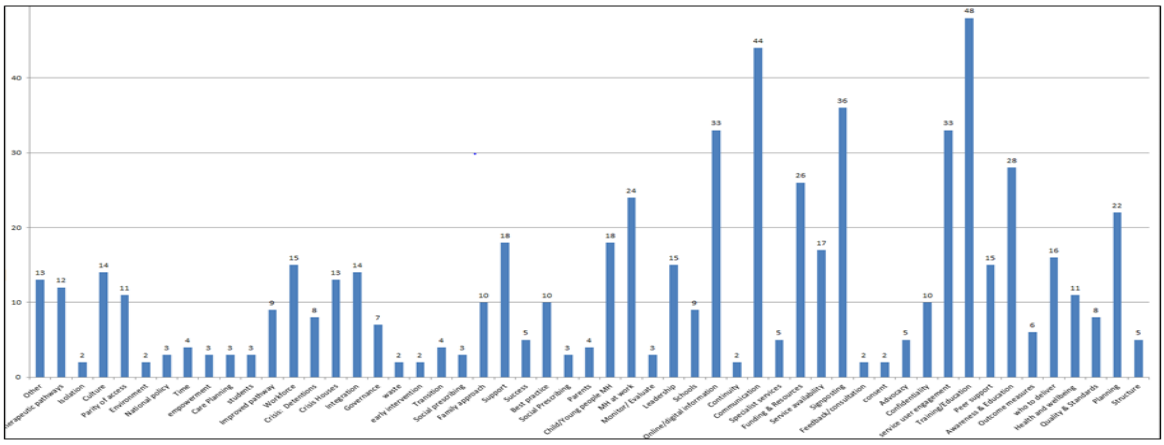
BSW has commenced talking and listening to local people and our partners to co-create our Thrive vision.

A Large Group Intervention (LGI) was held in December 2018 to commence our BSW wide engagement. An LGI is a type of multi-stakeholder event designed to "get the whole system in the room" in order to listen and develop shared understandings and agreements. The approach is one where people and staff work together on issues of mutual concern and strategic importance.

More than 183 individuals from 71 organisations participated in the day. Participants came from a wide range of backgrounds including the voluntary sector, statutory sector, clinicians, people with lived experience and carers.



Outputs were collated from 20 tables discussing differing topics. In total, 53 topic areas were highlighted during the event.



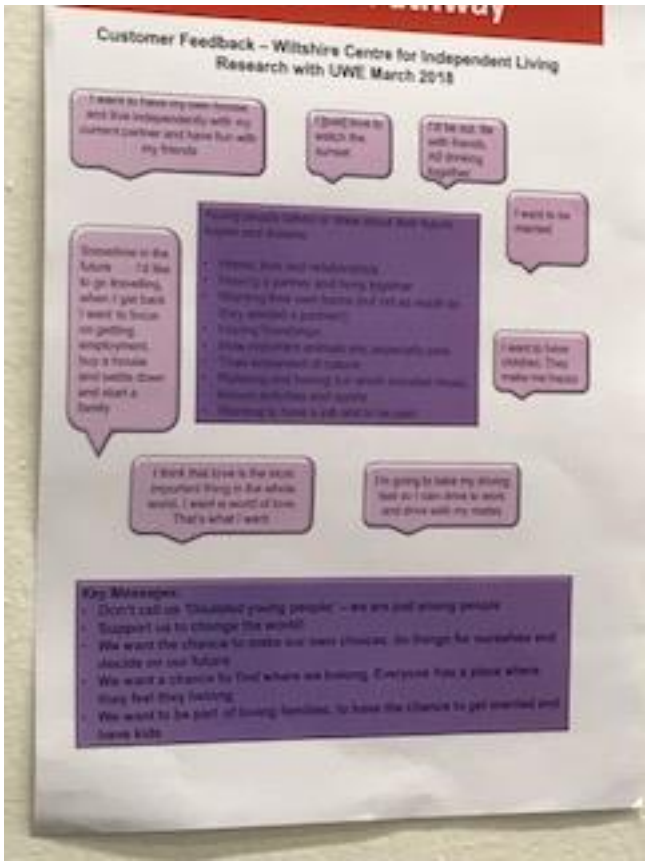
The key themes included:

- **Training and Education:** The main theme within this element was increasing the provision of training around mental health and mental wellbeing, both within communities, but also amongst professionals either working within the NHS or within the education sector.
- **Communication:** Key discussions hinged around the different tools and techniques for communicating messages, such as digital versus face to face.
- **Navigation:** This crossed over with communication, but was focused more on ways to ensure that people can access the right services at the right time for the right reason. There was less emphasis on methodology and more on the need to support and navigate people to the right service, ensuring that pathways are clear.
- **Service user engagement:** There was a clear view that involving service user and carers in the development of services was and should remain as the core of any strategy development and implementation, but that it required some culture change to achieve this effectively. This expanded to involving carers in the individual pathways of the service user and the importance of considering the whole family as part of end to end pathways. It was fedback that the term 'people with lived experience' was preferred to service users and hence this will be adopted by BSW Thrive.
- **Online/Digital:** The use of digital technologies was a key discussion point. There was acknowledgement that some research into technology should happen first, as systems and tools may already exist and therefore it would not be good to reinvent the wheel.

The feedback and outputs from the LGI have been used to co-create our draft conceptual model of care and define our vision and commitments. Our drafts will be discussed in detail at our second planned LGI event, which is being held on June 19th, to work together to progress actions and next steps.

The work to take this forward will be led by the Communications and Engagement Group that has been set up with a membership coming from the 3 CCGs (also representing their respective local authorities), the third sector and HealthWatch from each of the three areas, South, Central and West Commissioning Support Unit (SCWCSU) and each of the acute, community and mental health main providers for the BSW population. A key part of the work of the group is to co-ordinate, and advise on, engagement work with all stakeholders to ensure they are fully informed and involved in the work going forward and that this approach extends to any public consultation that may be necessary.

Engagement work has been undertaken in Wiltshire to listen to the views and experiences of young people with learning disabilities.

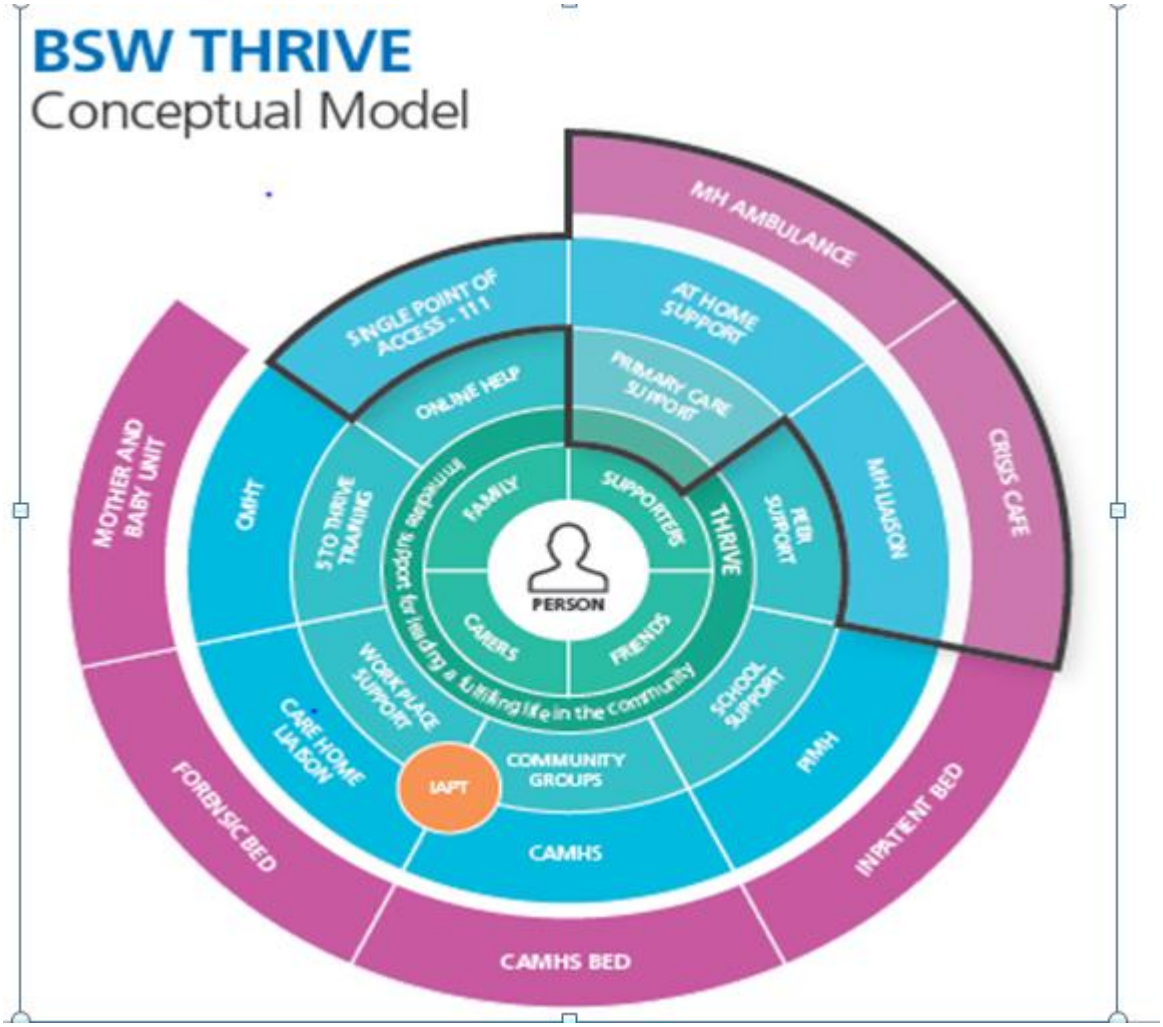


ADD in here Healthwatch survey

Link to Comms and engagement strategy

6 Our Conceptual model of care

Our BSW Thrive model of care has been co -produced with people and our partners. It puts the person using services at the heart of everything that we do.



7.1 Our commitments

Our commitment is to place the person needing support for their mental health at the centre of everything that we do.

We will build community wellbeing and resilience

- Build model of 'hope' around mental illness and enhance mental well being

We will empower people to grow, develop and connect
- Improved coordinated work with third sector across BSW
- Integrated practice between primary and secondary care
- Focus on early detection of dementia and review of memory clinic

We will redress balance between physical and MH and improve outcomes
- Physical health checks for individuals with Serious Mental Illness

We will listen and believe families and carers
- Dedicated comms and engagement group in place
- People with lived experience on MH programme board
- BaNES work on mental health charter and community engagement

We will provide better support for people in crisis
- The Junction Place of Calm to open in Swindon - May 2019
- Multi agency design work commenced for Salisbury Crisis Café Q2 opening planned
- New Personality Disorder pathway to be in place during 19/20
- New pathway for mental health crisis via 111/ IUC to be co-designed across BNSSG and BSW
- Planned review of mental health liaison including 24/7 need assessment

In order to support our work in enhancing the wellbeing of the BSW community we will:

Provide early help and navigation that is community based
- MH provision being co-designed for new Devizes build
- Collaborative work with local co-ordinators and High Intensity User service
- Link to development of Primary Care Networks across BSW

Develop our future workforce today
- Dedicated multi agency working group in place
- New roles being designed to fill known workforce gaps

Mental Health training to become main stream across communities and businesses
- Roll out of connect five training across employers
- MH first aiders for local businesses

Embrace digital solutions
- Planned pilot of skype consultations for BSW
- Review of all age on line counselling services to expand access
- Health Apps being explored
- One IAPT data recording system across BSW and BNSSG
- Potential for online step three IAPT CBT (IESO) to improve patient choice

To support delivery of our transformational commitments, we have agreed and developed the following work streams

7.2 Mental Health work streams

Work stream	Aims and Objectives	Outcome Measures	Lead and membership	Interdependencies
1. Implementing THRIVE and creating community resilience	• Increased social connectedness • Increase confidence that individuals can influence change in their lives and communities • Provide knowledge and skills so individuals and staff across statutory and voluntary sectors ensure that communities can make the changes they want • Build momentum for improvements in mental wellbeing – learning as we go • Roll out of mental health literacy training • Targeted work around military repatriation • Reduce social isolation	• Measure of 'hope' • Impact of training • Improvement in mental health inclusiveness • Mental health literacy training in 30% BSW employers or work places by 2021 • Experience measures	• Public Health lead • Service user/ Person with lived experience • Third sector rep • Local authority rep x 3 • Local co-ordinator rep • Wiltshire CIL • CCG rep • Provider reps • Police rep	• ITHRIVE for CYP • BaNES community mental health consultation

	• Continue to develop links to improve provision for individuals within or on the edge of the criminal justice system			
2. Providing early help and navigation that is community based	• Improved access • Creation of clear, evidence based pathway responses • Reduce escalation to crisis (including ED and GP on the day presentations) and inpatient admissions • Promote self-help agenda	• Recovery rates (including IAPT) • End to end pathway referral rates • Patient experience	• MH GP lead Dr Febin Basheer • PCN clinical director • CCG rep • Provider rep	• Primary care networks • Digital agenda • Workforce
3. Redress the balance between physical and mental health and improve outcomes	• Improved management of co-morbid physical health conditions • Improved health outcomes for individuals with MH diagnosis • Reduce preventable attendances to health care providers	• Reduced mortality rate for individuals with an SMI • Increase up take of physical health checks and physical health checks undertaken on admission • Reduction in smoking rates with SMI • Reduced preventable	• BSW STP commissioning lead – TBC • GPs • Public health • Providers • Third sector • Service user/ person with lived experience • ED rep from acute provider • SWAFT	• LD pathway review • DDR improvement plan

		physical health presentations for people with known MH condition		
4. Provide better support for people in crisis	• Reduce preventable attendances • Provide alternatives for self-navigation to individuals experiencing crisis • Increased use of community based alternatives • Building personal resilience • Improved pro-active management of at risk individuals (LD/ASD)	• Reduce inpatient admissions • Reduce 136/135 activity • Reduced suicide and self-harm rates • Reduced ambulance and police conveyance	• Caroline Mellers and Alex Luke • BSW STP commissioning leads • SWASFT • Police • People with lived experience • Providers (MH and acute) • GP • Local authority re step down • AMP rep	• Place based crisis café/ place of calm projects • 111/IUC MH pathway • Mental Health liaison review (Core 24)
5. Deliver safe, effective and accessible care	• Review of demand and capacity • Future proofing and building services for need and demographic change • Clarity on community provision and bed based need • Ensure bed base is geographically aligned to need	• OOA placements • NICE compliance delivery • Reduced preventable admissions • Improved well being demonstrated by clinically validated outcome measures – standard across	• BSW acting Programme Director – Lucy Baker • Providers • Third sector • Public health • Person with lived experience • Local authorities	• AWP service reconfiguration work stream • Estate work streams

	• Potential for outcomes based commissioning model	services		
6. Minimise the need for high intensity and OOA care and treatment	• Reduce preventable demand through alternative care pathways to prevent need for high intensity admission • Enhanced local MH health reduces need for specialist activity • Keeps people closer to home	• Admission rate reduction • Reduction in OOA placements • Reduction in non-contractual activity	• <u>Provider lead - Nicola Hazle AWP</u> • Specialist commissioners • Person with lived experience • Local Authority • CCG representatives • Quality (117 and specialist placements)	

6.3 Child and Adolescent Mental Health Services

A dedicated CAMHS transformation plan is in place across BSW to promote resilience, prevention, early intervention and to improve access. Our model of improved access includes a single point of access, online and self referral, group work for low mood and anxiety and counselling in the community.
Psychological wellbeing practitioners are in place offering a variety of support including worry management and cognitive restructuring.

CAMHS teams are being embedded across community and acute services including Emergency Departments, Adolescent and Looked After Children teams and schools. Swindon are a pilot site for the national trailblazer programme to deliver dedicated mental health teams in schools with Wiltshire and BaNES submitting a bid for the second wave of this programme during 19/20.

There is intensive community support in place seven days a week and 24/7 MH emergency cover for children and young people across BSW.

After year one of the new CAMHS model, we are taking stock and consulting with children, young people, parents/carers and professionals about the services on offer.

We already know that children and young people want help before they reach crisis point. They have told us:

"We want help and support at school, in our community and online"

"We don't want to end up in CAMHS"

"We don't always want our parents to know"

As part of the review, the commissioner has visited 2 of the 3 CAMHS teams (1 more to visit at end June), three parent meetings (organised by Wiltshire Parent Carer Council), 2 schools (meeting 11 young people) and has published surveys online (to date elliciting 146 responses).

From this feedback our commitments are:

- Recommissioning talking therapy services (including face-to-face, family therapy, online counselling, and positive. The new service will go live in April 2020. This new service will offer greater accessibiilty, wider reach and more innovation around early help.

- Facilitating a Youth Wellbeing Conference (12th November) which will be the launch event for developing a 'prevention partnership' in Wiltshire. Commissioning intentions are yet to be finalised through further co-production with service users, but this partnership is likely to be led by a community and voluntary sector organisation, also delivering talking therapies.

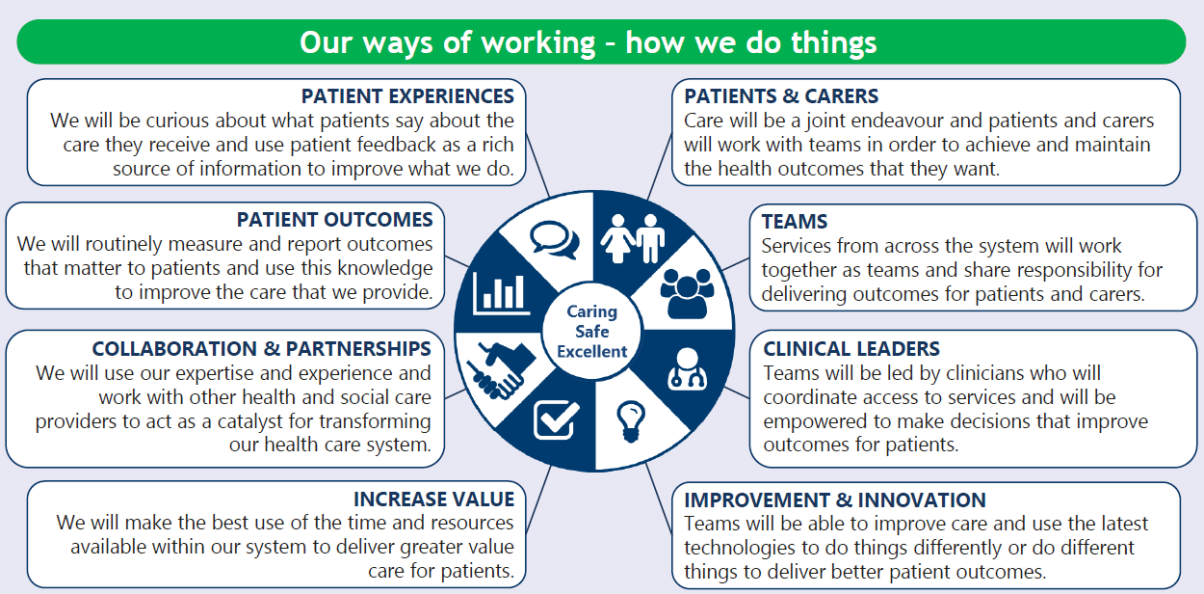
- Launching a Single Point of Access for CAMHS, which will offer greater responsiveness to pre-referral consultations for GPs and other referrers, as well as parents and carers.

- Investing in 'Thrive' and/or '5 to Thrive' training for early years, primary and secondary schools settings – to develop a whole-system approach to emotional wellbeing.

- Reviewing the use of embedded CAMHS practitioners in schools and children's services team to ensure that they are best placed and meeting the both early help and crisis care formulations.

- Awaiting the outcome of joint bid with BaNES to become a Mental Health Support Team Trailblazer area in Septemberr 2019.

We continue to work in partnership with Oxford Health to co-create and deliver our strategic transformation priorities. A summary of the Oxford Health Clinical Startegy features in appendix x and details the below model:



6.3 Place based models of care

BANES

Bath and North East Somerset (B&NES) Council and Clinical Commissioning Group (CCG) have been looking at the way community mental health services are delivered locally, to decide what improvements need to be made.

This builds on the priorities that were identified in the your care, your way review of community health and care services in 2015–17, and will help achieve positive changes in mental health and wellbeing provision for people living in B&NES.

People have told us that a new approach for delivering community mental health services must:

1. Focus on helping people, wherever possible, from reaching a point of crisis and having to get support at hospital.

2. Improve community-based support and ensure people get the right support, at the right time from specialist mental health services, particularly when they're experiencing crisis.

YOU SAID...
- Pre-crisis and staying well are one and the same thing. We need an integrated approach to ensure that services engage with people early.
- Social prescriptions – which would be provided by GPs – should be offered as part of a staying well service.
- There are a lot of services that people don't know about. We need to map these services and ensure that GPs are aware of them and can refer people to the appropriate support.
- We need community connectors/navigators who can support people to access services.

3. Make sure that services are more joined-up and work together better.

YOU SAID...
- People using mental health services currently have a disjointed experience and we need to make sure there are no gaps and overlaps between services.
- It is important for services to work together and be inclusive.
- People have to tell their story repeatedly to the professionals involved with their care.

4. Make sure that more information is shared, and people are aware about what support is available.

YOU SAID...
- We need to improve the signposting of services and ensure people don't fall through the gaps.
- Services aren't visible enough and more outreach is needed.
- We need a directory that GPs are aware of, so they can refer people to the appropriate support.

5. Improve coordination across mental, physical, social and wellbeing services in the community.

YOU SAID...
- There are a lot of different services in B&NES but they do not always work well together.
- People would like care coordination to be available in the community before people 'enter the system' e.g. community connectors in Frome.

6. Improve how people are connected from one service to another and ensure people don't fall through the gaps, as well as providing the right support for GPs and other healthcare professionals.

YOU SAID...
- For many it is a disjointed experience and they are 'passed around services.'

7. Have a 'Think Family' approach, with strong links between children and young people's and adult services.

YOU SAID...
- Support for the whole family, not just the individual, is key.
- Some carers feel undervalued and may not get the support they need.

8. Improve support for young people aged 16-25, including those moving from child to adult services.

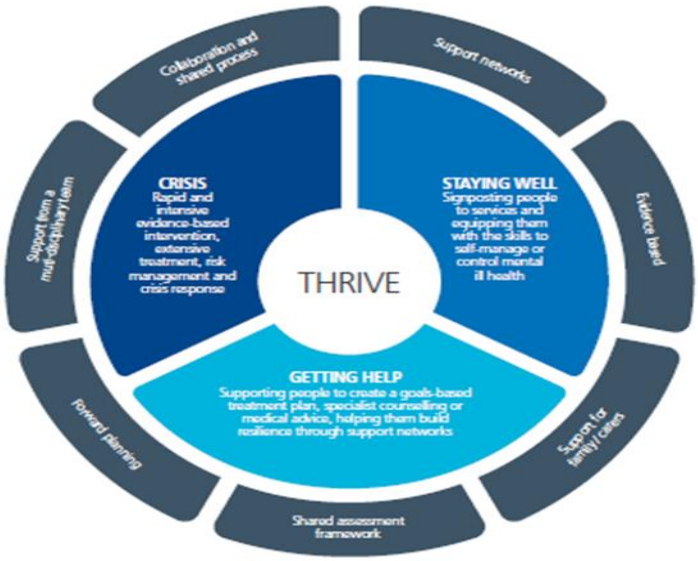
YOU SAID...
- There is a lack of information on what support and services are available for young people. We need an online directory (that is kept up to date).
- Wellbeing and mental health service provision needs to be grouped according to specific age groups e.g. 16+ and then older age groups.
- There needs to be more continued support for young people who transition from child to adult services and 'shared transition standards' developed for all services working with 16-25 year olds.

BaNES identified the Thrive approach as the preferred model of community mental health provision, which fits within our BSW Thrive strategy. The Thrive approach replaces the current 'tier' pathway or model of care with 'clusters' or 'groups.' These groups are:
STAYING WELL – Signposting people to services and equipping them with the skills to self-manage or control mental ill health.

GETTING HELP – Supporting people to create a goals-based treatment plan, specialist counselling or medical advice, helping them build resilience through support networks.

CRISIS – Rapid and intensive evidence-based intervention, extensive treatment, risk management and crisis response.

Thrive recognises that people may access services across all of these groups or just one and will need to be supported appropriately whatever their level of need. This is depicted in the diagram below:



Swindon

- CCG working with Swindon Borough Council regarding re-procurement of Community Mental Health Services in Swindon
- public consultation events Oct 18 & Feb 19
- on-line Public Consultation Survey "What helps you to manage your mental health?"
- Gaps identified:
  - Reach: increase reach of services
  - High risk groups: services to target high risk groups who are under-represented
  - Specific service gaps of perinatal mental health and suicide bereavement counselling
- additional recurrent financial investment from Swindon CCG

Aims of new Community Mental Health Wellbeing Services (CMHWS) from January 2020

- Tackle stigma, promoting inclusion
- Raise awareness of mental health and wellbeing
- Improve collaborative working in the mental health and wellbeing sector to achieve better outcomes
- Reduce hospital admissions for self harm and suicide rate
- Reduce demand on health and social care services
- Improve employment, volunteering, and mainstream integration of those with poor mental health
- Ensure services communicate and work together

Embedded Throughout Service

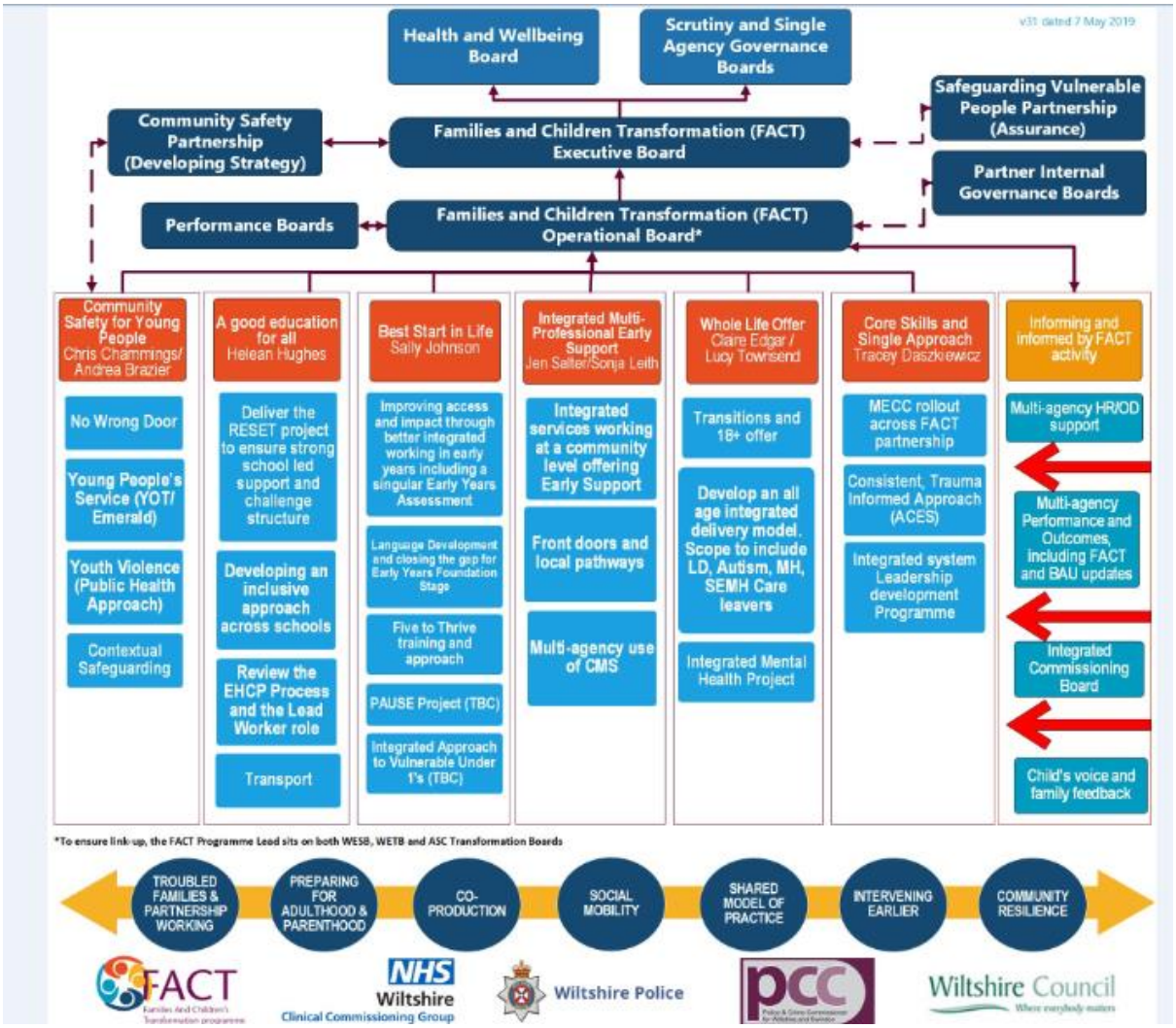
- Inclusion
- Promotion of Healthy Lifestyles
- Campaigns/ Awareness raising

Additional CCG investment specifically supports:

- Additional 1-2-1 support workers to help transitions and recovery from AWP and CAMHS + augment signposting to support those less able/ less motivated.
- Self Harm interventions -prevention/step down/recovery
- Additional funding support for those bereaved by suicide
- Online support for out of hours provision
- Website development and maintenance for the whole wellbeing service to increase digital offer
- Increase opportunity for prevention

Wiltshire

A dedicated Families and Children's Transformation (FACT) Programme is in place in Wiltshire, which includes a focus on early intervention and prevention for mental health. This features below:



A new Whole Life Pathway work stream has also commenced with a focus on LD and ASD. Wiltshire is planning to review its current mental health offer as aprt of the overarching BSW strategy. This will include formal review of services including police control room triage.

Community resilience has been a key focus in Wiltshire with the development of local coordinators to help provide local support for local people.

More to come

6.4 Primary Care Networks

Concern has been raised regarding the risk of individual PCNS developing their own mental health plans and in particular target recruitment of MH workers. A BSW wide MH Masterclass is planned to bring together PCN leads, commissioners, providers and the third sector to explore options and offers. The event will include a national speaker and examples of country wide models already in place with the aim to co-design a vision for the future.

6.5 Long Term Plan and FYFV

The NHS Long Term plan features a greater ask for transformation of all age mental health provision. The key elements highlighted are:

- Early intervention and prevention – particular ask around school based service for Children and Young People
- Expansion of crisis services– roll out of crisis café, Core 24 services, home treatment models, mental health ambulance and IUC/111
- Improvement in transitional care
- Creation of 16-25 service
- Review of community mental health model particularly around Serious Mental Illness (SMI)
- IAPT access expansion
- Reduction in suicide rates and bereavement support ending OOA placements by 2021

Our BSW Thrive strategy aims to address these highlighted areas, which link with transformation themes highlighted during the first Large Group Intervention engagement event.

8 Finance

In line with the Mental Health Investment Standard, investment in mental health has increased significantly over across BSW during the past two years and for 19/20, is expected to exceed £119m (excluding LD and dementia services). This represents a 13% increase from 17/18 and a 20% increase from 16/17

The table below details the Mental Health Investment spend for BSW:

BSW Total	£k		
Spend Categories (per Non-ISFE Reporting)	18/19 FOT (at M9)	MHIS increase Required	19/20 Planned Spend (indicative)
Children & Young People's Mental Health (excluding LD)	12,023	817	12,839
Children & Young People's Eating Disorders	340	23	363
Perinatal Mental Health (Community)	50	349	399
Improved access to psychological therapies (adult)	5,350	732	6,082
A and E and Ward Liaison mental health services (adult)	3,056	293	3,349
Early intervention in psychosis 'EIP' team (14 - 65)	1,326	109	1,435
Crisis resolution home treatment team (adult)	3,899	320	4,219
Community Mental Health	33,240	1,578	34,818
SMI Physical Health	1,746	205	1,951
Other adult and older adult - inpatient mental health (excluding dementia)	25,354	2,052	27,406
Other adult and older adult mental health - non-inpatient (excluding dementia)	10,411	493	10,904
Mental health prescribing	5,469	366	5,836
Mental health in continuing care	9,452	214	9,666
Total MH Spend (excluding Learning Disabilities & Dementia)	**111,716**	**7,552**	**119,268**

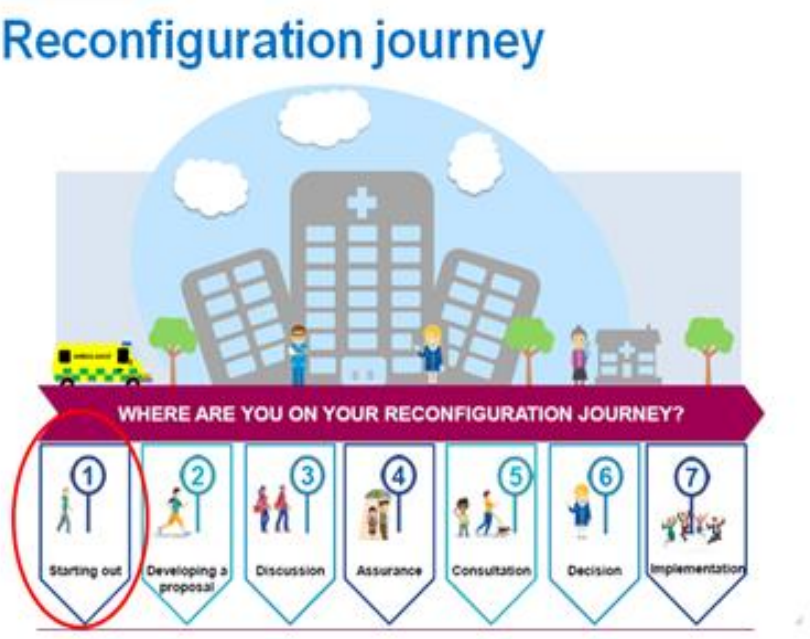
To support transformation, BSW have submitted or are submitting a number of local, regional and national bids. These are detailed below:

Bid	Type	Value	Lead/ Deadline
1. Community mental health transformation including older people, SMI/ PD and 18-25 BSW passed initial sieve and are in phase two of bidding round	National	£2.5m- £4m Two years recurrent (reduced to top envelope of £3.6m for year two)	June 20th LB/GR/AWP
2. Crisis support	Regional/ national	C £700k	June 18th LB/GR/AWP
3. Wave two CAMHS trail blazer (BaNES and Wiltshire) Mental Health School Teams	National	C £1.8m	SUBMITTED JE/MF
4. New identify for MH OOH provision	Local	C £136k	SUBMITTED – awaiting update on next steps LB/GR/AWP/MEDVIVO
5. Pump prime for personality disorder pathway across BSW – known commissioning gap and LTP ask	Local	C £134k	SUBMITTED Initial feedback bid unsuccessful. Looking at linking into bid 1 above. GR/NH
6. Bridging Gaps – Strengthening Mental Health Support (CYP) (Comic Relief)	National	C £150k to £700k per project	IN DEVELOPMENT Wiltshire place based bid with Community First JE

7 AWP service Reconfiguration

BSW will be leading a formal service reconfiguration exercise to review the type, number and location of adult mental health beds and current AWP community provision. This exercise will follow the NHSE five step process and commenced in December 2018. The following table details timeframes for this work:

Activity	Timeframe
Clinically led scoring of scenarios from long list to short list	May 2019
Development of comms and engagement plan	May 2019
Development of bed based demand and capacity model	June 2019
Review of community provision and locations	June 2019
Informal discussion on clinical case for change with Clinical Senate	Sept 2019
Formal clinical senate panel	Dec 2019
Potential commencement of public consultation	March – April 2020



Our emerging proposals include:

- Review of current AWP bed base provision across BSW footprint
- All beds in scope – need to link with commenced HBPOS and Daisy Unit reviews and redesign
- Possible opportunities for co-location of physical and mental health services on acute hospital sites (GWH and SFT)
- Aims to deliver higher intensity, therapeutic interventions in more specialised fit for purpose units
- Aligns with increasingly place-based community services, delivered in community hubs
- Espoused delivery of reduction in length of stay and improved experience and outcomes
- Clustered and strategically located units comprising of four or more wards to mitigate risk and improve resilience
- Aims to improve recruitment and retention by creating more supportive culture for staff with co-located services
- Enables new ways of working, reducing reliance on hard to recruit professions
- Reduces functionally unfit estate and backlog burden by driving efficiencies
- Reduces leased estate and enables consolidation of sites, release of land and buildings
- Risk presented by non-functionally suitable estate is significantly reduced, and improves regulatory compliance
- Co-creates an environment that is tailored to needs of patients, visitors and staff

A dedicated MH Reconfiguration Steering Group is in place to oversee this process and meets monthly. Membership includes commissioners, provider, people with lived experience, estates, comms and engagement and our lead BSW MH GP. A total of 18 scenarios have been developed as a long list of options, which were subject to a scoring panel on May 24th to create a short list for further engagement. The clinically led panel included clinicians from primary and MH services, person with lived experience, third sector representative, commissioners and estate team.

8 Our Transformation Priorities

Perinatal and Infant Mental Health

A new specialist BSW Community Perinatal Mental Health Service launched on April 1st 2019 which aims to promote maternal wellbeing, and parent-infant attachment. A hub and spoke model is in place, which is designed to enable distribution of specialist practitioners across BSW. There is a central base in Chippenham with satellite clinics in Salisbury, Bath and Swindon. The team are also able to see people at home, and will complete joint assessments with other professionals including health visitors and midwives.

The new service is aimed at moderate to severe perinatal presentations - during and up to 1 year post pregnancy. There is a heavy focus on working holistically with the mother with a strong emphasis on therapeutic interventions.

Suicide Prevention

BSW is working together to reduce suicide throughout the area. Every suicide is a tragic event and has devastating impacts on families, friends and communities. A BSW Suicide Prevention Strategy has been drafted, which acknowledges the benefits of working together

Our vision is that:

All partners within the STP suicide prevention network are committed to:

- *Reducing suicide, attempted suicide and self-harm.*
- *Ensuring that no resident will think that suicide is their only option*
- *Tackling the stigma associated with suicide*
- *Supporting those who are affected by suicide.*

1. **MYTH:** People who talk about suicide do not intend to do it.

   FACT: People who talk about suicide may be reaching out for help or support. A significant number of people contemplating suicide are experiencing anxiety, depression and hopelessness and may feel that there is no other option.

2. **MYTH:** Most suicides happen suddenly without warning.

   FACT: The majority of suicides have been preceded by warning signs, whether verbal or behavioural. Of course there are some suicides that occur without warning. But it is important to understand what the warning signs are and how to look out for them.

3. **MYTH:** Someone who is suicidal is determined to die.

   FACT: On the contrary, suicidal people are often ambivalent about living or dying. Someone may act impulsively by drinking pesticides, for instance, and die a few days later, even though they would have liked to live on. Access to emotional support at the right time can prevent suicide.

4. **MYTH:** Once someone is suicidal, he or she will always remain suicidal.

   FACT: Heightened suicide risk is often short-term and situation-specific. While suicidal thoughts may return, they are not permanent and an individual with previously suicidal thoughts and attempts can go on to live a long life.

5. **MYTH:** Only people with mental disorders are suicidal.

   FACT: Suicidal behaviour indicates deep unhappiness but not necessarily mental disorder. Many people living with mental disorders are not affected by suicidal behaviour, and not all people who take their own lives have a mental disorder.

6. **MYTH:** Talking about suicide is a bad idea and can be interpreted as encouragement.

   FACT: Given the widespread stigma around suicide, most people who are contemplating suicide do not know who to speak to. Rather than encouraging suicidal behaviour, talking openly can give an individual other options or the time to rethink his/her decision, thereby preventing suicide.

Source: World Health Organization, Preventing suicide: A global imperative (1)

Crisis avoidance and pathways

BSW have been working collaboratively to review current pathways for early intervention and prevention for people at risk of MH crisis. We have submitted an STP bid to revolutionise the design and delivery of out of hours support for our local populations. We plan to create a single point of access via 111 and linked to our established Integrated Urgent Care model, which links with the aims specified in the Long Term Plan. We will then co-design a hub and spoke model to better use our valuable staffing resource across BSW to provide both universal and targeted support that meets individual needs.

BSW has been working at a local level to co-design our Place of Calm/ Crisis Café services. This provision aims to provide support for local people in their community to reduce the risk of de-stabilisation and crisis.

The Junction 2 year pilot project was implemented on 3 June 2019 for people in Swindon aged 18+ years to access if they are experiencing a mental health crisis. The service will be open 365 days per year from 18.00 to 01.00 each day. The service is run by Swindon MIND, with wellbeing support workers offering holistic support in a non-clinical and supportive environment in the middle of Swindon. Qualified professional staff will support the wellbeing workers to help safely manage people in crisis. The service will be working closely with AWP Intensive Service. Although initially referrals will be from AWP Intensive Service only, there is an ambition to widen access and move from crisis management to prevention.

BaNES have co-created a model of crisis support called 'The Breathing Space'. This will be opening in the centre of Bath in xxx. Wiltshire are actively planning there community crisis support Place of Calm in Salisbury. We have a strategic third sector partner in place with a co-designed pathway developed.

Personality Disorder Pathway

People with personality disorders are currently cared for within core mental health teams and psychological treatment services across BSW. We recognise the need for further work to develop and improve provision for people with personality disorder across BSW, and are committed to ensuring this is a priority. Work has already started to scope and map what is already in place and gathering views and information from key partners and individuals with lived experience to inform future developments. This work includes:

- Working with AWP to deliver a project to develop the personality disorder pathway across BSW
- Personality Disorder Workshop Events; first held July 2019
- Development of workforce to support this work

Single point of access for MH referrals

Listening to people, primary care and our other partners, we have commenced a review of how people access mental health support. We want to make this as easy as possible and to ensure people get the help they need as close to their home. We aim to create a single point of access with an enhanced triage model to ensure people access the right services and the right time. We also hope this model will support GP resilience. This work will closely link with our planned changes to our out of hours model as described above.

Supporting community resilience

Work has already been undertaken in the BaNES geography with the creation of a BaNES Mental Health and Wellbeing Charter. Within Wiltshire, there are local co-ordinators supported by the local authority to help people in their communities and a pilot scheme supported by the Wiltshire Centre for Independent Living to help provide targeted community help. A scoping exercise will be undertaken across BSW all current activities and identify gaps. This will be completed by December 2019.

Early Intervention and prevention

To be added with development of Primary Care Networks

Increasing Mental Health Literacy

A mapping exercise is currently being led by the public health team in Wiltshire across BSW to review what training is available and planned to support improved mental health literacy across communities and employers.

Post diagnosis ASD pathways and Review of LD services (including the Daisy)

We have acknowledged a commissioning gap across BSW for providing support and intervention for Children, young people and adults diagnosed with ASD. We are working with people, families and our partners and learning from best practice to understand what such a service should look like.

A focus area for our strategic transformation will be a review of the current services and pathways for people with learning disabilities. This will be undertaken at scale and at a local, place based level. An initial BSW wide workshop was held earlier this year with a commitment to focus on key areas including:

- The development of dynamic risk registers to better understand the needs of our local populations and better proactively manage risk
- A review of the current Daisy provision and focus on improving the environment and support for residents
- Whole age pathway review within Wiltshire
- Thematic analysis from Blue Light Calls and No Blame Case Reviews to form a basis for our transformational change

Older people review including review of memory clinic pathways

We have heard feedback that our memory service pathways needs to be modernised. This work will initially be focused in Wiltshire and Swindon and a co-design workshop is planned before the Autumn.

9 Workforce

Our workforce is key to delivering our strategy and transformational improvements. We know we have challenges across our mental health services in relation to recruitment and retention. We have developed a dedicated MH workforce working group to agree actions and monitor progress. This will link with both place based and at scale activities and monitored via the LWAB. Workforce activities currently underway include:

- Extended use of apprenticeships
- Widening our flexible working offer – increasing Bank pool for BSW
- Associate Psychologists
- Associate Physicians
- Advanced Clinical Practitioners
- Non-medical Approved Clinicians
- Peer Support Workers

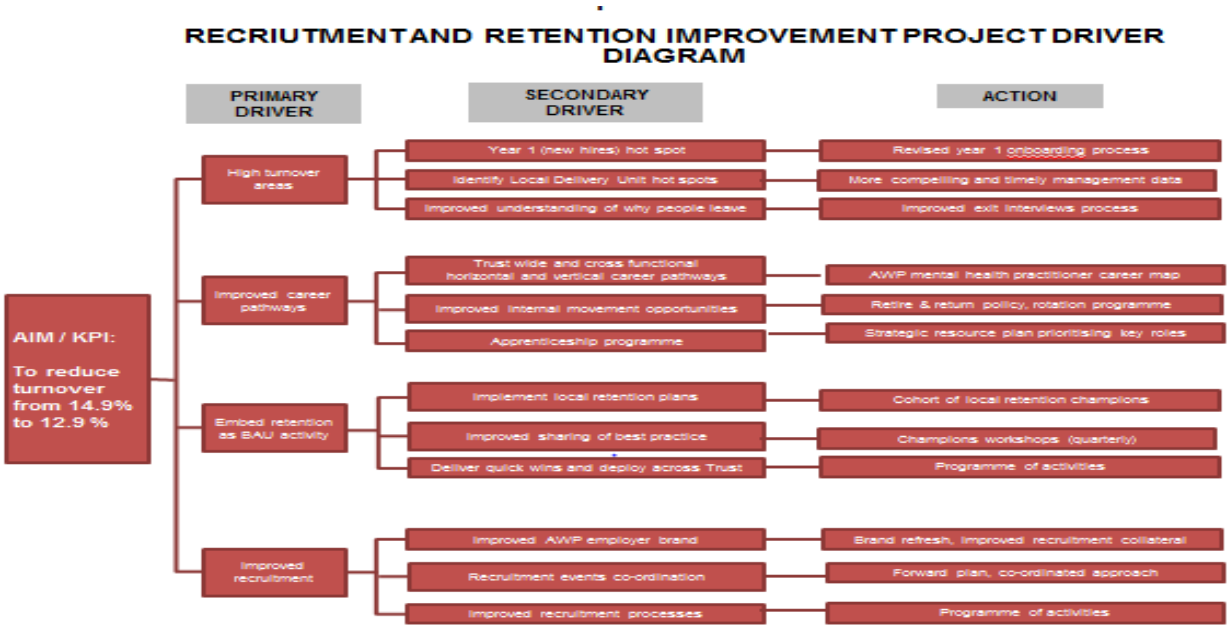
We have also identified some priority work force areas. These include the need for parity between third sector and NHS terms and conditions to support delivery of new integrated models of care between our partners and designing tomorrow's mental health workforce today.

The table below details the current MH staff expansion plans for BSW:

2019 Update - Staff Establishment Expansion to date

Expansion by staff group & service area in FTE

Expansion	Medical	N&M	AHP (STT)	Total Clinical	Support	Admin	Total
CYP	0	0	1.6	1.6	0	0	1.6
Adult IAPT	0	0	0	0	0.3	0	**0.3**
Perinatal	0	7	1	8	0.6	2	**10.6**
Crisis	0	0	0	0	0.7	0	**0.7**
E.I.P	0	0	0.1	0.1	0.6	0	**0.7**
Liaison	0	19.7	1.9	21.6	0	0	**21.6**
Core Acute	0	9.2	5.8	15	0	0	**15**
Core Community	0.4	8.6	6.7	15.7	5.4	0	**21.1**
Other	0	0	0	0	0	0	0
TOTAL	**0.4**	**44.5**	**15.5**	60.4	**7.6**	**2**	**70**



10 Digital Opportunities

We are working across providers and with the BSW Digital work stream to identify digital opportunities to support our mental health transformation work.

Priorities

Priorities arise in the following areas: (insert links to documents when published)

- Our Clinical Health and Care strategy
- BSW's Operational Plan for 2019/20
- National drivers to be Digital First
- NHS Long Term Plan
- Local priorities

These are summarised as:

Improving the Health & Wellbeing of our Population	**such as supporting people to take more responsibility for their health and wellbeing and seeking to involve the third sector and communities in the planning, provision and delivery of care**
Developing Sustainable Communities	through the delivery of joined up efficient and effective primary, community and social care services, appropriately scaled
Sustainable secondary care services	by Acute Hospitals Alliance partners working together to address capacity issues; specialties under pressure; back office services and co-designing care pathways
Transforming care across BSW	focusing initially on Mental Health, Maternity and Outpatient Services
Creating strong Clinical Networks	with Clinical Leadership driving the development and

	implementation of BSW Five Year Strategy to deliver the NHS Long Term Plan which we will support by investing in clinical leadership development, quality improvement methodology and workforce training to support service transformation
A fit for purpose digital infrastructure and capability	To support delivery of these priorities by enabling staff and people to promote, give and receive care in the most efficient and effective way

The digital strategy supports delivery of these priorities and responds to the stated challenges, working to ensure that the system of health and care is financially sustainable whilst delivering on the digital vision.

	For people	For staff
	**I know how to look after my own health and care** • knowing I am using reference tools and materials that are safe and proven to work, whether I am a cancer survivor or someone whose mental health has improved • I can visit the NHS App store and download clinically approved Apps to help me be as healthy as possible and / or to manage my condition if I have one • I'm confident that when I talk to my care worker or clinician that the info in the app is telling them what they need to know to be able to help me • Greater participation in Public Health initiatives such as Stoptober, Dry January	Commissioners and Local Authorities have put in place a BSW App store with approved Apps that can be prescribed (where there is a cost) as well as support and training for primary and community care and people to use the Apps to support prevention and self-care, reducing demands into primary care
	I can look after my mental health better • Clinicians can prescribe Apps and/or use tele-psychiatry to support self-care and my condition as part of my Wellness, Recovery, Action & Plan for my mental health condition, • By working in partnership with my care provider in this way, I am helping to reduce the likelihood of my condition escalating, reducing demands into the mental health system, helping me to stay where I am by getting help and support when I need it, before things get worse for me	Commissioners and Local Authorities have put in place a BSW App store with approved Apps that can be prescribed (where there is a cost) as well as support and training for primary and community care and people to use the Apps to support prevention and self-care, reducing demands into primary care

Transformation capabilities underpinning the strategy

A skilled, enabled and equipped workforce	An informed and enabled population
Investing in and enabling our staff - staff will be supported to become confident in the use of digital technology through training and development (such as Royal College of Nursing's Every Nurse an e-Nurse competencies, improved training for CCIOs)	Engage on a multi-agency basis in the Good Things Widening participation programme for digital
Health and care staff are fully mobile and connected within BSW seamlessly to their home network, regardless of which health and care setting they are in results in less dead travel time going to and from base to access records and information; facilitating more patient contact time	Enabling people to use digital health and are solutions - work with Local Government and other agencies to provide education on how to use Apps and link wearables to their own devices using networks such as Age UK, social prescribers etc.
Mobile, remote, peripatetic working requires digital proficiency and competence if staff are to be productive. As a way of working, it also requires staff and managers to be able to manage through outcomes rather than traditional 'attendance'.	Help people and their carers with their own devices so that they can use Apps, wearables and assistive technologies effectively so that forecast benefits are realisable, establish and deliver 'user surgeries'
Staff will have the right tools for the job and are confident in their use e.g. mobile devices (either use their own or be provided with them) that are suited to the task including staff will be able to drive less miles to service meetings by using tools such as Skype / WebEx, freeing up productive time, reducing carbon emissions	Educating our young people - drive uptake of access to digital health and care solutions in families e.g. establish and deliver talks in schools and other settings to educate on the changes in health and care that digital will enable for people and their families e.g. an intro to the NHS App and how to use it
Cyber aware staff is a critical line of defence in cyber security. Staff are any organisations greatest protection in cyber security; Regular ongoing training and education is a necessary part of helping to keep records and information secure.	Reduce digital exclusion - free Wi-Fi available in all health and care settings so people can access digital solutions
E-rostering in all acutes with benefits including better safety, accurate payroll system, better shift planning, a fairer rostering system, and freeing up clinical time for direct patient care	Free computing for people with no access to digital solutions is already available in Local Government libraries
Increased clinician and practitioner satisfaction with IT and digital solutions, because they are enabled by the technology; technology is not a barrier	Information about health and care services that are available will be easily surfaced through a single portal which uses artificial intelligence and Chabot's using natural language processing to get you to the right information, first time
• Increase in flexible and peripatetic working and a reduction in dead travel time and carbon emissions (calculated as a reduction in business miles) • Improve recruitment and retention in some settings by enabling clinical and non-clinical staff to work flexibly and peripatetically supported by technology	End of life computing equipment will be passed for secure wiping and repurposing by schemes that sell refurbished equipment at reduced prices to target groups for example students, people on benefits
Innovation – we will actively horizon scan and engage with digital innovators in heath and care, Co-producing with staff, the people we care for and potential suppliers to improve people's outcomes in a way that is sustainable	

Our BSW initial work streams include:

- Progressing skype consultations
- Exploring the best options for connecting primary care and mental health clinicians to improve advice and guidance services particularly around medication
- Expanding the current use of online counselling facilities